

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 12496

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# 12471

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Salisbury</u>		<u>All life.</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>129 Second Street</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
<u>Betty</u>		<u>Ann</u> <u>Austin</u>		<u>12-</u> <u>31-</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>G</u>	<u>Married</u>	<u>6-24-30</u>	<u>25</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>School nurse</u>		<u>Salisbury High School</u>		<u>Salisbury, Md.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Raymond Purnell</u>				<u>Allene Dasheill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>		<u>No</u>		<u>214-30-8392</u>		<u>Calvin Austin-127 Second St., Salisbury, Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>6510</u> Immediate cause (a) <u>Infected abortion</u> DUE TO						<u>21 hrs.</u>	
Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-3-56</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-4-56</u>		<u>Green Acres Memorial Park</u>		<u>Salisbury, Wicomico, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-4-56</u>		<u>Mary W. Holloway</u>		<u>STEWART FUNERAL HOME</u>		<u>SALISBURY MARYLAND</u>	

RECEIVED

JAN 6 - 1956

BUREAU V. S.

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12472

## 12497 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b> COUNTY <b>Wicomico</b>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>Most of life</b>		TOWN <b>Salisbury</b>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>At home - Shumaker Road</b>				STREET ADDRESS (If rural give location) <b>Shumaker Road</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>German Francis Barkley</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>12 - 16 - 19 55</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>A.A.</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>1899</b>	
<b>9. AGE last birthday</b> <b>56 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bus Operator</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>School Bus</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Snow Hill, Worcester Co. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Winfield Barkley</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Townsend</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Salisbury, Md.</b>			
				<b>Charles G. Barkley, Jersey Road.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1</b> IMMEDIATE CAUSE (A) <b>Coronary Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Coronary Insufficiency</b>				<b>2 months</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Hypertension</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Oct 3, 1955, to Dec 16, 1955, that I last saw the deceased alive on Dec 6, 1955, and that death occurred at 4:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>L.H. Sensible</i>				<b>DATE SIGNED</b> <i>Dec 16/55</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>24. REC'D BY REGISTRAR</b> <b>12-20-55</b>			
<b>DATE THEREOF</b>				<b>NAME OF CEMETERY OR CREMATORY</b> <b>Green Acres Memorial Park</b>			
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mary W. Holloray</i>				<b>ADDRESS</b> <b>Salisbury, Wicomico Co., Md.</b>			
<b>26. REGISTRAR'S SIGNATURE</b> <i>Mary W. Holloray</i>				<b>27. FUNERAL HOME</b> <i>J.F. Stewart Funeral Home, Salisbury, Md.</i>			
<b>DATE</b> <b>12-19-55</b>							

# 1957 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Page Two

1. PLACE OF DEATH

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. TIME OF BIRTH

7. PLACE OF DEATH

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22. PLACE OF BIRTH

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31. PLACE OF DEATH

32. DATE OF DEATH

33. TIME OF DEATH

34. PLACE OF BIRTH

35. DATE OF BIRTH

36. TIME OF BIRTH

BUREAU V. S.

DEC 22 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

12473

12498

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 332

Item 12 Film 101 1-11-56 at

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> LENGTH OF STAY (In this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>700 W. Isabella St.</u>		STREET ADDRESS (If rural, give location) <u>705 W. Isabella St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Milton</u> (Middle) <u>O.</u> (Last) <u>Bell</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Dora Bell</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>		<u>minutes</u>	
Antecedent cause(s) (b) <u>advanced arteriosclerosis</u>		<u>10-15 years</u>	
(c) <u>Hypertension</u>		<u>years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>W. B. S. Tene</u>		ADDRESS <u>109 Fern St Salisbury</u>	
DATE SIGNED <u>12/28/55</u>			
23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		DATE THEREOF <u>12-31-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Foreston Cem</u>		LOCATION (City, town, or county) <u>Salisbury MD</u>	
24. FUNERAL DIRECTOR <u>Booker M. West</u>		ADDRESS <u>12-29-53 Mary W. Holloway</u>	

RECEIVED

JAN 2 1966

BUREAU V. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12474

## 12548 CERTIFICATE OF DEATH

Reg. Dist. No. 332

Item 9, Film 191 1-6-56 et

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Bivalve</i>	<i>Lifetime</i>	TOWN <i>Bivalve</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<i>Oscar D. Bradley</i>		<i>12-30 1955</i>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b>	<b>8. DATE OF BIRTH</b>
<i>M</i>	<i>W</i>	<i>Widowed</i>	<i>3-19-1889</i>
<b>9. AGE last birthday</b>		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)	
<i>67 1/2</i>		<i>9 11</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<i>Mechanic</i>		<i>Garage (Auto)</i>	
<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY</b>	
<i>Riverton, Md.</i>		<i>U.S.</i>	
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
<i>Atlas Bradley</i>		<i>Lda. Phillips</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<i>No</i>		<i>213-18-3050</i>	
<b>17. INFORMANT &amp; ADDRESS</b>		<b>18. MEDICAL CERTIFICATION</b>	
<i>Harry Bradley, Bivalve, Maryland</i>		<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>	
		<b>19. DATE OF OPERATION</b>	
		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)	
<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <i>4/12/54</i> to <i>12/30</i>, 19<i>55</i> that I last saw the deceased alive on <i>12/30</i>, 19<i>55</i>, and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.</b>			
<b>SIGNATURE</b>		<b>DATE SIGNED</b>	
<i>D. Paul H. Saunders, M.D.</i>		<i>12/31/55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>24. REC'D BY REGISTRAR</b>	
<i>Burial</i>		<i>1/1/56</i>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>26. ADDRESS</b>	
<i>C. D. Messick</i>		<i>Bivalve, Md.</i>	

# STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE, MD. CERTIFICATE OF DEATH

Form No. 10-1

1. USUAL RESIDENCE (Home or place of abode)

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. DATE OF DEATH

5. MEDICAL EXAMINATION

BUREAU V. E.

JAN 4 1956

RECEIVED

INVESTIGATION

1. Name of deceased (Print or write full name)  
2. Sex  
3. Age  
4. Date of birth  
5. Place of birth  
6. Date of death  
7. Cause of death  
8. Medical examination  
9. Signature of physician  
10. Signature of registrar  
11. Signature of coroner  
12. Signature of medical examiner  
13. Signature of health officer  
14. Signature of chief of health department  
15. Signature of secretary of health department  
16. Signature of assistant secretary of health department  
17. Signature of chief clerk of health department  
18. Signature of assistant clerk of health department  
19. Signature of stenographer of health department  
20. Signature of messenger of health department  
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99. Signature of janitor of health department  
100. Signature of cook of health department



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS. AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 5, Film G191 1-13-56 et

12475

332

Dr. William Smith

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Fruitland</b>				TOWN <b>Fruitland</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>S. Division St Ext.</b>				<b>S. Division St Ext.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<b>LOUDER JOSEPH WASHINGTON BRUMBLEY</b>				<b>Dec. 3rd 1955</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Sept. 3, 1880</b>	<b>75</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>Janitor Fruitland Meth. Church</b>				<b>Dagsboro Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Joseph Brumbley</b>				<b>Rita Evans</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>				<b>Mrs. Bertha L. Brumbley (Wife) S.Div. St. Ext. Fruitland, Maryland</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <b>Cardiac Arrest</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Insufficiency</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Hypertension C.V. disease</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Organic insufficiency</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12-1</b> , 19 <b>55</b> , to <b>12-5</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>12-3</b> , 19 <b>55</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>W. B. Smith</b>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<b>Salisbury, Maryland</b>		<b>Dec. 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Dec. 6, 1955</b>		<b>Red Men Cemetery</b>		<b>Dagsboro, Delaware</b>	
24. REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>EC 7 1955</b>		<b>Mary H. Holloway</b>		<b>HOLLOWAY &amp; COMPANY</b>		<b>SALISBURY MARYLAND</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Manner of Death		Occupation	
Date of Death		Place of Death		Physician	
Signature of Physician		Signature of Registrar		Signature of Coroner	

BUREAU V. 21

DEC 7 1955

RECEIVED

12499

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 <u>Salisbury</u>				3 <u>Snow Hill</u>		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <u>December 18 1955</u>			
<u>Robert Lee Burgess</u>							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>				<u>Jan 14, 1886</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>69 yrs</u>		<u>11</u> Months <u>4</u> Days		<u>Hours</u> <u>Min.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Fisherman</u>				<u>Pocomoke River</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY:			
<u>Virginia Beach, Virginia</u>				<u>USA</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.			
<u>9</u>				<u>226-22-5640</u>			
17. INFORMANT & ADDRESS:							
<u>Mrs Margaret B. Burgess</u>				<u>Snow Hill, Md</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE							
(A) <u>Coronary Thrombosis</u>							
DUE TO							
(B) <u>Arteriosclerotic heart disease</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchiogenic carcinoma rt. main bronchus</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>2</u>							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-15</u> , 19 <u>55</u> , to <u>12-18</u> , 1955 that I last saw the deceased alive on <u>12-18</u> , 19 <u>55</u> , and that death occurred at <u>7:30</u> P. M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Carl W. Beardsley</u>				<u>12-21-55</u>			
M. D.				ADDRESS			
				<u>Salisbury Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
DATE THEREOF				LOCATION (City, town, or county) (State)			
<u>12-21-55</u>				<u>Chancock Cemetery Chancock, Va.</u>			
DATE REC'D BY LOCAL REGISTRAR				24. FUNERAL DIRECTOR			
<u>12-21-55</u>				<u>Clay E. Dennis, Snow Hill, Md</u>			

MARGIN RESERVED FOR BINDING

BUREAU V. S.

DEC 27 1955

RECEIVED

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12550

# CERTIFICATE OF DEATH

12571

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		STATE <i>md</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		OR TOWN <i>Wettpgum</i>		OR TOWN <i>Wettpgum</i>	
TOWN <i>Wettpgum</i>		<i>Life</i>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Lewis</i> (First) <i>S.</i> (Middle) <i>Conway.</i> (Last)				<b>4. DATE OF DEATH</b> (Month) <i>12</i> (Day) <i>26</i> (Year) <i>1955</i>			
5. SEX <i>m</i>	6. COLOR OR RACE <i>col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>1879</i>	9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Wettpgum</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Isiah Conway</i>				14. MOTHER'S MAIDEN NAME <i>Mary Weatly</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>216-14-2399A</i>		17. INFORMANT & ADDRESS <i>Mary R. Conway</i>			
(If Yes, give war or dates of service)							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
331X IMMEDIATE CAUSE (A) <i>Cerebral Vascular</i>						<i>24 hours</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio sclerosis</i>						<i>10 years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>1/12</i> <b>19</b> <i>52</i> <b>, to</b> <i>12/26</i> <b>19</b> <i>55</i> <b>, that I last saw the deceased</b> <b>alive on</b> <i>12/26</i> <b>19</b> <i>55</i> <b>, and that death occurred at</b> <i>6:00 P.M.</i> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <i>Richard H. Saunders</i> <b>M. D.</b> <i>Maubert W. West</i> <b>ADDRESS</b> (Street, city, town, state) <i>md.</i> <b>DATE SIGNED</b> <i>12/27/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-31-55</i>		NAME OF CEMETERY OR CREMATORY <i>Wettpgum Cem</i>		LOCATION (City, town, or county) (State) <i>md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary H. Hallways</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Zooker M. West.</i>		ADDRESS	
DATE <i>JAN 6 1956</i>							

BUREAU V. S.

RECEIVED  
JAN 6 1950

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. DATE OF DEATH	
7. TIME OF DEATH		8. CAUSE OF DEATH	
9. MEDICAL CERTIFICATE		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED	
39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED	
47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED	
63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED	
75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED	
83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED	
87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	



12500

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Worcester</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Salisbury</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Snow Hill</i>		<i>23x2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>Bay Street</i>			
3. NAME OF DECEASED: (First) <i>Elsie</i> (Middle) <i>B</i> (Last) <i>Cottingham</i>		4. DATE OF DEATH: (Month) <i>December</i> (Day) <i>25</i> (Year) <i>1955</i>					
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Nov. 24-1895</i>	9. AGE last birthday <i>60</i> yrs.	IF UNDER 1 YEAR: Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>		11. BIRTHPLACE (State or foreign country): <i>Sirdletree Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME: <i>Thomas Parker Bowen</i>		14. MOTHER'S MAIDEN NAME: <i>Emma W. Jones</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT & ADDRESS: <i>Mr. J. Wilson Cottingham, Jr., Snow Hill, Md</i>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>420.1</i>							
ANTECEDENT CAUSE (S) <i>Coronary Artery Thrombosis</i>				<i>Unknown</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>"</i> (C) <i>"</i>				<i>Heart Disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Pulmonary edema</i>				<i>15 min</i>			
<i>Cerebral Atherosclerosis</i>				<i>24 hr</i>			
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at <i>6 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>David J. Schum</i>		M. D. <i>Salisbury Md</i>		DATE SIGNED <i>Dec. 25 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>12-28-55</i>		DATE THEREOF <i>Presbyterian Cemetery</i>		LOCATION (City, town, or county) <i>Snow Hill, Md.</i>		(State) <i>Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>12-27-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. Holladay</i>		24. FUNERAL DIRECTOR <i>Clay E. Dennis</i>		ADDRESS <i>Snow Hill, Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. H. Moore

RECEIVED

DEC 29 1955

BUREAU V. S.

1  
M  
1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12501 CERTIFICATE OF DEATH

12479

Dr. Gilmore

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Wicomico</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Wicomico</b>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
12 TOWN <b>Salisbury</b>		OR TOWN <b>Salisbury</b>	12
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
00 311 Pryor Ave		311 Pryor Ave	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>MARY</b> (Middle) <b>WINONA</b> (Last) <b>COTTON</b>		(Month) <b>DEC.</b> (Day) <b>5</b> (Year) <b>th 19 55</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 26, 1916</b>
9. AGE last birthday <b>39</b> yrs.		IF UNDER 1 YEAR <b>10</b> Months <b>9</b> Days <b>9</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Forsythe Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin O. Childs</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Hollis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes) <b>No</b> (If Yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS <b>Mr. John C. Cotton (Husband) 311 Pryor Ave. Salisbury, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <b>Thrombia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Symptoms 6 mo.</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Intracapillary Glomeruloclerosis</b>		<b>1 yr.</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Diabetes Mellitus</b>		<b>about 5 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. et work) <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>March 1955</b> to <b>Dec 5 1955</b> , that I last saw the deceased alive on <b>Dec 5 1955</b> , and that death occurred at <b>2:20 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>David J. Schure</b> M.D.		ADDRESS (Street, city, town, state) <b>Medical Center Salisbury, Maryland</b> DATE SIGNED <b>Dec 5 / 55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec. 7 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		LOCATION (City, town, or county) (State) <b>Montgomery Maryland</b>	
24. REC'D BY REGISTRAR <b>DEC 14 1955</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A PUMPHREY</b>		ADDRESS <b>FUNERAL HOME-BETHESDA MD</b>	

CERTIFICATE OF DEATH

1945

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
John C. Gotten		Male		45		Jan. 25, 1900		Baltimore		Baltimore		Baltimore		Maryland	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY	
Salesman		High School		Married		Roman Catholic		Heart Disease		Natural		Baltimore		Baltimore	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
Dec. 1, 1945		Baltimore		Baltimore		Baltimore		Maryland		Dec. 1, 1945		Baltimore		Baltimore	

BUREAU V. S.

DEC 1 1945

RECEIVED

NOTED: Dec. 2, 1945  
Rockville Union  
Baltimore, Maryland

RECORDED  
INDEXED  
JAN 10 1946  
U.S. DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12502

## CERTIFICATE OF DEATH

12480

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>8 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>105 East Locust St.,</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>NETTIE FULTON COULBOURN</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>12 17 19 55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Dec. 18, 1879</u>		<b>9. AGE last birthday</b> <u>75</u> Yrs.	<b>IF UNDER 1 YEAR</b> Months Days	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Isaac P. Collins</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Ellen Dixon</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Floyd Bentley, Salisbury</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<u>3 days</u>	
<b>332X IMMEDIATE CAUSE (A)</b> <u>Cerebral Thrombosis</u>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (B)							
<b>STATING UNDERLYING CAUSE LAST, DUE TO</b> (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>12/18</u>, 19<u>55</u>, to <u>12/17</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/17</u>, 19<u>55</u>, and that death occurred at <u>3:55</u> P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>J. R. Grasse</u>				<b>DATE SIGNED</b> <u>12/19/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12/20/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Parsons Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Salisbury, Maryland</u>	
<b>24. RECEIVED BY REGISTRAR</b> <u>DEC 22 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hill &amp; Johnson Co. Salisbury, Maryland</u> <u>Norman F. Baker</u>			

# CERTIFICATE OF DEATH

1955

Reg. Dist. 12

1. CAUSE OF DEATH

2. PLACE OF DEATH

3. MANNER OF DEATH

4. MEDICAL HISTORY

5. OCCUPATION

6. RESIDENCE

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. SEX

11. RACE

12. AGE

13. MARITAL STATUS

14. EDUCATION

15. RELIGION

16. SOCIAL CLASS

17. PRESENT ILLNESS

18. PREVIOUS ILLNESSES

19. PRESENT TREATMENT

20. PREVIOUS TREATMENT

21. PRESENT PHYSICIAN

22. PREVIOUS PHYSICIAN

23. PRESENT HOSPITAL

24. PREVIOUS HOSPITAL

25. PRESENT NURSE

26. PREVIOUS NURSE

27. PRESENT ATTENDING PHYSICIAN

28. PREVIOUS ATTENDING PHYSICIAN

29. PRESENT MEDICAL EXAMINER

30. PREVIOUS MEDICAL EXAMINER

31. PRESENT CORONER

32. PREVIOUS CORONER

33. PRESENT JURY

34. PREVIOUS JURY

35. PRESENT VERDICT

36. PREVIOUS VERDICT

BUREAU V. S.

DEC 22 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12481

## 12503 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>md</i> COUNTY <i>Wicomico</i>		CITY (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		CITY (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	
12 TOWN <i>Salisbury</i>		LENGTH OF STAY (in this place) <i>Life</i>		TOWN <i>Salisbury</i>		12	
82 HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Gen. P. Hosp</i>				STREET ADDRESS (if rural give location) <i>511 Collins St</i>			
3. NAME OF DECEASED (Type or Print) <i>Burn</i> (First) <i>A.</i> (Middle) <i>Cuff</i> (Last)				4. DATE OF DEATH <i>12</i> (Month) <i>7</i> (Day) <i>1955</i> (Year)			
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>April 9, 1877</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Barber</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>Wicomico co</i>	Months <i>2</i>	Days <i>1</i>	Hours <i>1</i> Min. <i>4</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Ellis Cuff</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Adkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Y</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Armelia Cuff</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <i>Cardiovascular Renal Lesions</i>							
DUE TO ANTECEDENT CAUSE(S) (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>8</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12-6</i> , 19 <i>55</i> , to <i>12-7</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12-7</i> , 19 <i>55</i> , and that death occurred at <i>4:20</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Theresa Long</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury md</i>		DATE SIGNED <i>12-13-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-14-55</i>		NAME OF CEMETERY OR CREMATORY <i>Gloss Hill Cem. Parsonsburg md</i>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <i>12-14-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Booken W. Lusk</i>		ADDRESS	

BUREAU V. S.

DEC 16 1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12504

## CERTIFICATE OF DEATH

12482

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wic omico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 hrs.</u>		TOWN <u>Laurel</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>926 West Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Gertude</u> (Middle) <u>Hopkins</u> (Last) <u>Culver</u>				(Month) <u>Dec.</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Dec. 15, 1880</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Irvin H Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Elizabeth Hopkins, Laurel, Del.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>acute coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>atherosclerosis</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14-2-55</u> to <u>17-2-55</u> , that I last saw the deceased alive on <u>1-7-29</u> , 19 <u>55</u> , and that death occurred at <u>8:22 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. H. Holloway</u> M.D.				ADDRESS (Street, city, town, state) <u>18730/55</u> DATE SIGNED <u>1/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		LOCATION (City, town, or county) <u>Laurel, Delaware</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co</u>		ADDRESS <u>Delmar Del.</u>	
DATE <u>JAN 6 1956</u>							

# CERTIFICATE OF DEATH

Reg. No. 1234

1. NAME OF DECEASED: JOHN DOE

2. SEX: Male

3. AGE: 45

4. DATE OF BIRTH: JAN 15 1880

5. PLACE OF BIRTH: BALTIMORE, MD

6. OCCUPATION: Clerk

7. DATE OF DEATH: JAN 10 1925

8. PLACE OF DEATH: Baltimore, MD

9. CAUSE OF DEATH: Heart Disease

10. SIGNATURE OF PHYSICIAN: J. H. Smith

11. SIGNATURE OF CORONER: J. H. Smith

12. SIGNATURE OF REGISTRAR: J. H. Smith

13. SIGNATURE OF WITNESS: J. H. Smith

14. SIGNATURE OF WITNESS: J. H. Smith

15. SIGNATURE OF WITNESS: J. H. Smith

16. SIGNATURE OF WITNESS: J. H. Smith

17. SIGNATURE OF WITNESS: J. H. Smith

18. SIGNATURE OF WITNESS: J. H. Smith

19. SIGNATURE OF WITNESS: J. H. Smith

20. SIGNATURE OF WITNESS: J. H. Smith

21. SIGNATURE OF WITNESS: J. H. Smith

22. SIGNATURE OF WITNESS: J. H. Smith

23. SIGNATURE OF WITNESS: J. H. Smith

24. SIGNATURE OF WITNESS: J. H. Smith

25. SIGNATURE OF WITNESS: J. H. Smith

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50. SIGNATURE OF WITNESS: J. H. Smith

51. SIGNATURE OF WITNESS: J. H. Smith

52. SIGNATURE OF WITNESS: J. H. Smith

53. SIGNATURE OF WITNESS: J. H. Smith

54. SIGNATURE OF WITNESS: J. H. Smith

55. SIGNATURE OF WITNESS: J. H. Smith

56. SIGNATURE OF WITNESS: J. H. Smith

57. SIGNATURE OF WITNESS: J. H. Smith

58. SIGNATURE OF WITNESS: J. H. Smith

59. SIGNATURE OF WITNESS: J. H. Smith

60. SIGNATURE OF WITNESS: J. H. Smith

61. SIGNATURE OF WITNESS: J. H. Smith

62. SIGNATURE OF WITNESS: J. H. Smith

63. SIGNATURE OF WITNESS: J. H. Smith

64. SIGNATURE OF WITNESS: J. H. Smith

65. SIGNATURE OF WITNESS: J. H. Smith

66. SIGNATURE OF WITNESS: J. H. Smith

67. SIGNATURE OF WITNESS: J. H. Smith

68. SIGNATURE OF WITNESS: J. H. Smith

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70. SIGNATURE OF WITNESS: J. H. Smith

71. SIGNATURE OF WITNESS: J. H. Smith

72. SIGNATURE OF WITNESS: J. H. Smith

73. SIGNATURE OF WITNESS: J. H. Smith

74. SIGNATURE OF WITNESS: J. H. Smith

75. SIGNATURE OF WITNESS: J. H. Smith

76. SIGNATURE OF WITNESS: J. H. Smith

77. SIGNATURE OF WITNESS: J. H. Smith

78. SIGNATURE OF WITNESS: J. H. Smith

79. SIGNATURE OF WITNESS: J. H. Smith

80. SIGNATURE OF WITNESS: J. H. Smith

81. SIGNATURE OF WITNESS: J. H. Smith

82. SIGNATURE OF WITNESS: J. H. Smith

83. SIGNATURE OF WITNESS: J. H. Smith

84. SIGNATURE OF WITNESS: J. H. Smith

85. SIGNATURE OF WITNESS: J. H. Smith

86. SIGNATURE OF WITNESS: J. H. Smith

87. SIGNATURE OF WITNESS: J. H. Smith

88. SIGNATURE OF WITNESS: J. H. Smith

89. SIGNATURE OF WITNESS: J. H. Smith

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91. SIGNATURE OF WITNESS: J. H. Smith

92. SIGNATURE OF WITNESS: J. H. Smith

93. SIGNATURE OF WITNESS: J. H. Smith

94. SIGNATURE OF WITNESS: J. H. Smith

95. SIGNATURE OF WITNESS: J. H. Smith

96. SIGNATURE OF WITNESS: J. H. Smith

97. SIGNATURE OF WITNESS: J. H. Smith

98. SIGNATURE OF WITNESS: J. H. Smith

99. SIGNATURE OF WITNESS: J. H. Smith

100. SIGNATURE OF WITNESS: J. H. Smith

BUREAU V. S.

JAN 6 1925

RECEIVED

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JAN 10 1925  
BALTIMORE, MD  
STATE DEPARTMENT OF HEALTH  
RECEIVED

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12505 **CERTIFICATE OF DEATH**

12484

Items 8,9 FilmG191 1-23-56 et Item 3 FilmG192 1-31-56 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		STATE <i>md</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Salisbury</i>		STREET ADDRESS (If rural give location) <i>657 W. Main St</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Salisbury</i>		LENGTH OF STAY (In this place) <i>30 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Salisbury md</i>		STREET ADDRESS (If rural give location) <i>657 W. Main St</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>C. S. Hosp.</i>				STREET ADDRESS (If rural give location) <i>657 W. Main St</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Frank L. Dashiell</i>				<b>4. DATE OF DEATH</b> (Month) <i>12</i> (Day) <i>25</i> (Year) <i>1955</i>			
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>Sept. 15, 1877</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR Months <i>12</i> Days <i>25</i>		IF UNDER 24 HRS. Hours <i>19</i> Min. <i>55</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ordnance</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>White House</i>	
13. FATHER'S NAME <i>George Bushard</i>				14. MOTHER'S MAIDEN NAME <i>Josephine Gettes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>				16. SOCIAL SECURITY NO. <i>217-10-2326</i>		17. INFORMANT & ADDRESS <i>Donville Bushard</i>	
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cerebral hemorrhage</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>12-25-55</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>12-25-55</i> , <b>to</b> <i>12-25-55</i> , <b>19</b> <i>55</i> , <b>that I last saw the deceased alive on</b> <i>12-25-55</i> , <b>and that death occurred at</b> <i>7:30 P.M.</i> , <b>from the causes and on the date stated above.</b>							
SIGNATURE <i>Paul A. Insley</i>				ADDRESS (Street, city, town, state) <i>Salisbury md</i>		DATE SIGNED <i>10-28-55</i>	
23. BURIAL, CREMATION, REMOVAL SPECIES <i>12-29-55</i>		DATE THEREOF <i>12-29-55</i>		NAME OF CEMETERY OR CREMATORY <i>Green Acres Cem</i>		LOCATION (City, town, or county) (State) <i>Salisbury md</i>	
24. REC'D BY REGISTRAR <i>JAN 6 1956</i>		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Barth M. West</i>		ADDRESS	



15401

# CERTIFICATE OF DEATH

Reg. Dist. No.

A. DEATH OCCURRED IN HOME OR CHURCH

B. PLACE OF DEATH

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH
AGE	SEX	RACE
EDUCATION	RELIGION	DATE OF BIRTH
DATE OF DEATH	TIME OF DEATH	CAUSE OF DEATH

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH
AGE	SEX	RACE
EDUCATION	RELIGION	DATE OF BIRTH
DATE OF DEATH	TIME OF DEATH	CAUSE OF DEATH

II. MEDICAL EXAMINATION

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH
AGE	SEX	RACE
EDUCATION	RELIGION	DATE OF BIRTH
DATE OF DEATH	TIME OF DEATH	CAUSE OF DEATH

BUREAU V. S.

JAN 6 1956

RECEIVED

RECEIVED  
JAN 6 1956  
BUREAU V. S.



12485

## MARYLAND STATE DEPARTMENT OF HEALTH

12506

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Eden</b>	
HOSPITAL OR INSTITUTION OR P.G. Hospital STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <b>Lee</b> (Middle) <b>F.</b> (Last) <b>Dashiell</b>	4. DATE OF DEATH (Month) <b>Dec.</b> (Day) <b>4</b> (Year) <b>55</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, <del>WIDOWED</del> <b>divorced</b> (Specify)	8. DATE OF BIRTH <b>Oct. 10, 1878</b>
9. AGE last birthday <b>77</b> yrs.		10. If under 1 year: Months <b>19</b> Days <b>8</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Davied Dashiell</b>		14. MOTHER'S MAIDEN NAME <b>Anna Dashiell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>219-14-2916</b>	
17. INFORMANT <b>Archie Dashiell</b>		<b>Eden, Md.</b>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
931X Immediate cause (a) <b>Cerebral Hemorrhage Dec 4-55</b> Antecedent cause(s) (b) <b>Fall and fracture right hip on Dec. 2, 1955</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Dec. 2, 1955</b>			<b>12 hrs</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
TIME (Month) (Day) (Year) (Hour) <b>Dec 2-55 1 P.m.</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) <b>Eden</b> (COUNTY) <b>Somerset</b> (STATE) <b>Md.</b>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <b>R.H. Johnson M.D.</b>		DATE SIGNED <b>Dec 6-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>12-7-1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Flower Hill Cemetery</b>		LOCATION (City, town, or county) <b>Eden, Maryland</b> (State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>12-7-55 Mary W. Hollaway</b>		24. FUNERAL DIRECTOR <b>Levin B. Wilson</b> ADDRESS <b>Princess Anne, Maryland</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Nov 2 1952

For the purpose of  
conducting research

BUREAU V. 2

DEC 9 1955

RECEIVED

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12507 **CERTIFICATE OF DEATH**

12486

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		1 week		TOWN <u>Bishopville</u>		238-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>--</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Willis</u> (Middle) <u>James</u> (Last) <u>Davis</u>				(Month) <u>Dec.</u> (Day) <u>6,</u> (Year) <u>1955</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>White</u>		<u>Single</u>		<u>Mar. 12, 1882</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, or retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>House painter</u>		<u>painting</u>		<u>Ocean View, Delaware</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>James Davis</u>				<u>Mame (Mary) Taylor</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>Unk.</u>		<u>-- no</u>		<u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Nephrosclerosis</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>--</u>		<u>--</u>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		<b>21d. HOW DID INJURY OCCUR?</b>	
<input type="checkbox"/>		<u>Office bldg., etc.</u>		<u>(County)</u>		<u>(State)</u>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
<b>22. I hereby certify that I attended the deceased from</b> <u>Nov. 30, 1955</u> , <b>to</b> <u>Dec. 6, 1955</u> , <b>that I last saw the deceased alive on</b> <u>Dec. 6, 1955</u> , <b>and that death occurred at</b> <u>9:05 a.m.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Dr. V. Juerman</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Deer's Head State Hospital, Salisbury, Md.</u>			
<b>DATE THEREOF</b> <u>Dec. 9, 1955</u>				<b>DATE SIGNED</b> <u>12/6/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county)			
<u>Burial</u>		<u>Old Fellows</u>		<u>Bishopville, Md.</u>			
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>12-9-55</u>		<u>Mary L. Holman</u>		<u>Henry S. Watson</u>			
<b>DATE</b>				<b>ADDRESS</b> <u>Beowoke City</u>			

CERTIFICATE OF DEATH

1512

1. Name of deceased

2. Sex

3. Age

4. Race

5. Date of birth

6. Place of birth

7. Date of death

8. Place of death

9. Cause of death

10. Signature of attending physician

11. Signature of medical examiner

12. Signature of registrar

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery official

17. Signature of burial society official

18. Signature of interment society official

19. Signature of crematorium official

20. Signature of other official

BUREAU V. 5

DEC 19 1975

RECEIVED

## 12508 CERTIFICATE OF DEATH

Reg. Dist. No. 12482 832

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>6 day</u>		CITY (If outside corporate limits, write TOWN and give nearest town) <u>Frankford</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>R.F.D. #3</u>			
3. NAME OF DECEASED: (First) <u>Dorothy</u> (Middle) <u>E.</u> (Last) <u>Dorman</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 11</u> 19 <u>55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Sept 28 1903</u>	
				9. AGE last birthday <u>52</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House Wife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>John Shockley</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah M. Evans</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Lloyd Dorman Frankford Del</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE				(A) <u>Myocardial Insufficiency</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Coronary Artery Heart Disease</u>			
				DUE TO			
				(C) <u>Chronic Pyelonephritis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				<u>Hepholithiasis</u> <u>Severe Anemia</u>			
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 11, 1955</u> to <u>Dec. 11, 1955</u> that I last saw the deceased alive on <u>Dec 11, 1955</u> and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>David L. Schure</u>				ADDRESS <u>Salisbury</u>		DATE SIGNED <u>Dec. 11 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 14 1955</u>		<u>Baldwin Cemetery</u>		<u>Dagsboro Del</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-12-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Watson &amp; Guy</u>		ADDRESS <u>Frankford Del</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 14 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12488

12509

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		Since <u>9/9/55</u>		TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>115 First Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Charlotte</u> (Middle) <u>Adelate</u> (Last) <u>Dulin</u>				(Month) <u>Dec.</u> (Day) <u>8</u> (Year) <u>1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Aug. 26, 1878</u>	<u>77</u> yrs.	Months <u>3</u>	Days	Hours <u>3</u> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>				<u>Marion Station, Maryland</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Henry James Johnson</u>				<u>Mary Ann Boston</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>unk</u>		<u>None</u>		<u>self on admission</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<u>002X</u> IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>9/9/55</u>, 19....., to <u>12/8/55</u>, 19....., that I last saw the deceased alive on <u>12/8/55</u>, 19....., and that death occurred at <u>3:05 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>M.D.</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Lee L. Lawry</u>		<u>Fruitland, Maryland</u>		<u>12/8/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county)	
<u>BURIAL</u>		<u>DEC. 11, 1955</u>		<u>ST. PAUL'S CEMETERY</u>		<u>MARION STATION, MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>12-13-55</u>		<u>Mary W. Holloman</u>		<u>Bruckshaw &amp; Sons - Cinfield, Md.</u>			

DEC 16 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12510  
Items 18221d Film 6191 1-9-56 ans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

R# 12489  
No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>7</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>Westover Hill</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John</u> <u>Duncan, Jr.</u>				<u>12-</u> <u>31-</u> <u>19 55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>11-5-1932</u>	9. AGE last birthday: <u>23</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Shroutland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Duncan Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Christyford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>John Duncan Sr.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Hemorrhage due to multiple stab wounds of chest and abdomen.</u>							
Antecedent cause(s) (b) <u></u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION: <u>12-31-55</u>				19b. MAJOR FINDING OF OPERATION: <u></u>			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Home.</u>		21c. (City or town) (County) (State): <u>Salisbury Wicomico Maryland.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>12- 31 55 12:45 PM</u>		21e. INJURY OCCURRED While at <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Stabbed by another man in fight.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-3-56</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1-4-56</u>		NAME OF CEMETERY OR CREMATORY: <u>mt Calvary Cem</u>		LOCATION (City, town, or county) (State): <u>Shroutland Md</u>	
DATE REC'D BY LOCAL REG. <u>1-4-56</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>Brooks m West Salisbury Md</u>		ADDRESS: <u></u>	

BUREAU V. S.

JAN 6 1952

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 12511

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **12490**  
No. **331**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 days</u>		TOWN <u>Sharptown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>Main Street</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH			
(Type or Print)		<u>Calvert Thomas Elliott</u>		<u>12 9 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Aug. 22, 1899</u>	<u>56</u> yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Machinist</u>		<u>Manfg.</u>		<u>Maryland</u>		<u>U S A</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William E. Elliott</u>				<u>Hessie Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>				<u>Mrs. Mary Elliott-wife.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						hours.....	
<u>912.3</u> Immediate cause (a)..... <u>Pulmonary edema.</u> DUE TO						2 days.....	
Antecedent cause(s) (b)..... <u>Tetanus.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)..... <u>Infected left thumb, compound fracture.</u>						10 days.....	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY?	
<u>1-8-55</u>		<u>Tracheotomy.</u>				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)		21c. (City or town) (County) (State)			
		<u>Factory</u>		<u>Hebron Wicomico Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11 30 55</u> M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
				<u>Caught thumb between a chain and a rail.</u>			
22. I hereby certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , <u>Suicide</u> <input type="checkbox"/> , <u>Homicide</u> <input type="checkbox"/> , <u>Undetermined cause</u> <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Earl L. Royce</u>		<u>12/12/55</u>		<u>Freemans</u>		<u>Sharptown, Md</u>	
DATE REC'D BY LOCAL REG.		REGISTER'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12-12-55</u>		<u>Mary W. Holloman</u>		<u>Earl L. Royce</u>		<u>Sharptown, Md</u>	

RECEIVED

DEC 14 1955

BUREAU V. S.



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12491

## 12512 CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wic.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury, Maryland</u>		<u>2 yr. 4 mo. 11 days</u>		TOWN <u>Delmar</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. #3</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Sam</u> <u>Evans</u>				<u>Dec.</u> <u>11</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Widowed</u>	<u>Dec. 25, 1891</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>unk</u>		<u>unk</u>		<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME <u>George Evans</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unk</u>		<u>unk</u>		<u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>15. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>443x</u> <u>Recurrent Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular disease</u>						<u>unk</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis General</u>						<u>unk</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 30, 19 53</u> , to <u>Dec. 11, 19 55</u> , that I last saw the deceased alive on <u>Dec. 11, 19 55</u> , and that death occurred at <u>6:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. V. Guerman</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>			
				DATE SIGNED <u>Dec. 11, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>12-14-55</u>		<u>Green Acres Cem</u>		<u>Salisbury, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-20-55</u>		<u>Mary W. Holloway</u>		<u>J. J. Tucker</u>		<u>W. J. Tucker</u>	

15941

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# CERTIFICATE OF DEATH

Form 100-100

DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND

OFFICE OF DEATH

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

AGE  
SEX  
RACE  
BIRTH DATE  
BIRTH PLACE

EDUCATION  
OCCUPATION  
MARRIAGE  
PREVIOUS ILLNESS

PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL

PREVIOUS TOBACCO  
PREVIOUS CIGARETTES  
PREVIOUS SMOKE  
PREVIOUS OTHER

PREVIOUS OTHER  
PREVIOUS OTHER  
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PREVIOUS OTHER

BUREAU V. S.

DEC 23 1955

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RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		3½ months		OR TOWN <u>Baltimore</u>		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
91 <u>Deer's Head State Hospital</u>				2801 Edison Highway ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) <u>George</u> (Middle) <u>Joseph</u> (Last) <u>Fitch</u>				(Month) <u>Dec.</u> (Day) <u>13</u> (Year) <u>19 55</u>			
6. SEX	7. COLOR OR RACE	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	9. DATE OF BIRTH	10. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Widowed	5/17/1882	73 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		--		Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Fitch</u>				<u>Mary Roth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		?		Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				Cerebral thrombosis			
ANTECEDENT CAUSE(S) DUE TO				Arteriosclerosis, general			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Hypertensive arteriosclerotic cardiovascular disease			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 23</u> , 19 <u>55</u> , to <u>Dec. 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 12</u> , 19 <u>55</u> , and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>V. Juerman</u> V. Juerman, M.D.;				DATE SIGNED <u>12/13/55</u>			
ADDRESS (Street, city, town, state)							
<u>Deer's Head State Hospital</u>				<u>Salisbury, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 16, 1955		Oak Lawn Cemetery		Baltimore, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>Dec. 16, 1955</u>		<u>Mary H. Hollings</u>		<u>Schimunek Funeral Home, Inc.</u>			
				<u>2601-3-5 E. Madison St.</u>			

## INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

15230

INVESTIGATING DEPARTMENT OF HEALTH-BALTIMORE 10

# CERTIFICATE OF DEATH

15213

Page One of Two

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF DECEASED

16. SIGNATURE OF SURVIVORS

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF BURIAL SOCIETY

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INVESTIGATOR

22. SIGNATURE OF CLERK

23. SIGNATURE OF OFFICIAL

24. SIGNATURE OF JURY

25. SIGNATURE OF DECEASED

26. SIGNATURE OF SURVIVORS

27. SIGNATURE OF FUNERAL HOME

28. SIGNATURE OF BURIAL SOCIETY

29. SIGNATURE OF CEMETERY

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INVESTIGATOR

32. SIGNATURE OF CLERK

33. SIGNATURE OF OFFICIAL

34. SIGNATURE OF JURY

35. SIGNATURE OF DECEASED

36. SIGNATURE OF SURVIVORS

37. SIGNATURE OF FUNERAL HOME

38. SIGNATURE OF BURIAL SOCIETY

39. SIGNATURE OF CEMETERY

40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INVESTIGATOR

42. SIGNATURE OF CLERK

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86. SIGNATURE OF SURVIVORS

87. SIGNATURE OF FUNERAL HOME

88. SIGNATURE OF BURIAL SOCIETY

89. SIGNATURE OF CEMETERY

90. SIGNATURE OF INTERVIEWER

91. SIGNATURE OF INVESTIGATOR

92. SIGNATURE OF CLERK

93. SIGNATURE OF OFFICIAL

94. SIGNATURE OF JURY

95. SIGNATURE OF DECEASED

96. SIGNATURE OF SURVIVORS

97. SIGNATURE OF FUNERAL HOME

98. SIGNATURE OF BURIAL SOCIETY

99. SIGNATURE OF CEMETERY

100. SIGNATURE OF INTERVIEWER

101. SIGNATURE OF INVESTIGATOR

BUREAU V. S.

DEC 19 1955

RECEIVED

ENCLOSURE

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12493

## 12514 CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12</u> <u>SALISBURY</u>		LENGTH OF STAY (In this place) <u>1 WEEK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>		<u>19X2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springhill Sanitarium, Inc.</u>				STREET ADDRESS (If rural give location) <u>RURAL #2</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>HAROLD</u> (First) <u>H.</u> (Middle) <u>GIBBONS</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>DEC.</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAY-10-1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months   Days		IF UNDER 24 HRS. Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <u>RETIRED FARMER (OWN)</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ISAAC GIBBONS</u>				14. MOTHER'S MAIDEN NAME <u>PRECILLA PARONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>HAROLD H. GIBBONS, JR.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
442X IMMEDIATE CAUSE (A) <u>Cardiovascular renal disease</u>				<u>BALTIMORE</u> <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/10</u> , 19 <u>55</u> , to <u>12/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>55</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Henry A. Tushy</u>		M.D. <u>Salisbury Md</u>		ADDRESS (Street, city, town, state) <u>12-20-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC 9 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>	
24. REC'D BY REGISTRAR <u>12-20-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Tushy</u>		ADDRESS <u>Princess Anne Md.</u>	



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BUREAU V. B.

DEC 23 1955

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12494

## 1251 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 months</u>		TOWN <u>Tilghman</u>		<u>20x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Alfred James Harrison</u>				<u>Dec. 11 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>2/23/1875</u>	<u>80</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Unknown</u>			<u>- -</u>		<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Harrison</u>				<u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>?</u>		<u>Hospital records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
422.1 IMMEDIATE CAUSE (A) <u>Hypostatic pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) <del>XXXXX</del>						<u>3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO						<u>?</u>	
904.9 (C) <u>Arteriosclerotic cardiovascular disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Intertrochanteric fracture of right femur</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 6</u> , 19 <u>55</u> , to <u>Dec. 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 11</u> , 19 <u>55</u> , and that death occurred at <u>5:40 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>				DATE SIGNED <u>12/12/55</u>			
ADDRESS (Street, city, town, state) <u>L.V. Maldve, M.D.; Deer's Head Hospital Salisbury, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>12/14/55</u>	<u>Tilghman M.C.</u>		<u>Tilghman Talbot Md</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			
<u>DEC 16 1955</u>	<u>Mary H. Holloway</u>			<u>J. Leeds Moore - Tilghman, Md</u>			

1-1404

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

Reg. No. 100

1. DECEASED'S NAME (Last, first, middle)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. DATE OF BIRTH (Month, day, year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (If any)

7. CAUSE OF DEATH (Immediate)

8. CAUSE OF DEATH (Underlying)

9. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)

10. SIGNATURE OF PHYSICIAN (Name, Title, Address)

11. SIGNATURE OF REGISTRAR (Name, Title, Address)

12. SIGNATURE OF WITNESSES (Name, Address)

13. SIGNATURE OF DECEASED (If able to sign)

14. SIGNATURE OF CLERK (Name, Title, Address)

15. SIGNATURE OF CHURCH CLERK (Name, Title, Address)

16. SIGNATURE OF BURIAL SOCIETY (Name, Title, Address)

17. SIGNATURE OF FUNERAL HOME (Name, Title, Address)

18. SIGNATURE OF CORONER (Name, Title, Address)

19. SIGNATURE OF JURY (Name, Title, Address)

20. SIGNATURE OF JUDGE (Name, Title, Address)

21. SIGNATURE OF DISTRICT ATTORNEY (Name, Title, Address)

22. SIGNATURE OF COUNTY CLERK (Name, Title, Address)

23. SIGNATURE OF STATE CLERK (Name, Title, Address)

24. SIGNATURE OF U.S. DEPARTMENT OF HEALTH (Name, Title, Address)

25. SIGNATURE OF U.S. DEPARTMENT OF JUSTICE (Name, Title, Address)

26. SIGNATURE OF U.S. DEPARTMENT OF AGRICULTURE (Name, Title, Address)

27. SIGNATURE OF U.S. DEPARTMENT OF COMMERCE (Name, Title, Address)

28. SIGNATURE OF U.S. DEPARTMENT OF EDUCATION (Name, Title, Address)

29. SIGNATURE OF U.S. DEPARTMENT OF INTERIOR (Name, Title, Address)

30. SIGNATURE OF U.S. DEPARTMENT OF LABOR (Name, Title, Address)

BUREAU V. S.

DEC 16 1955

RECEIVED

PHOTOCOPYED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12495

Dr. Saunders 12551

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Quantico</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Quantico</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. # 1</u>				STREET ADDRESS (If rural give location) <u>R.D. # 1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MAE</u> <u>HESTER</u> <u>HAYWARD</u>				<b>4. DATE OF DEATH</b> (Month) <u>DEC.</u> (Day) <u>26</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 28, 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wango Md. (Near Salisbury)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Austin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lee (Unk)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Myrtle Griffin (Daughter) R.D. # 1 Quantico, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
171X IMMEDIATE CAUSE (A) <u>Carcinomatous</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cervical Cancer</u>				<u>3 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Transition</u>				<u>1 month</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>2/1</u> , 19 <u>54</u> , to <u>12/26</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>54</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above. <b>SIGNATURE</b> <u>D. H. Saunders</u> M.D. <u>Nantuxche Md.</u> <b>DATE SIGNED</b> <u>27 Dec. 1955</u> <b>ADDRESS</b> (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bivalve Cemetery</u>		LOCATION (City, town, or County) (State) <u>Bivalve, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

U. S. BUREAU

1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC-45 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12497

12516

## CERTIFICATE OF DEATH

Dr. Beardsley

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>ANN ST.</b>			
3. NAME OF DECEASED (First) <b>MARY</b> (Middle) <b>ELLEN</b> (Last) <b>HEARNE</b>				4. DATE OF DEATH (Month) <b>DEC.</b> (Day) <b>17</b> (Year) <b>19 55</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 11, 1889</b>	9. AGE last birthday <b>66</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Asbury Elliott</b>				14. MOTHER'S MAIDEN NAME <b>Laura Perdue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. Gardner T. Hearne (Husband) Pine Bluff State Hospital- Salisbury, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>congestive heart failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>degenerative heart disease</b>				<b>5 yrb.</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12-14-55</b> , to <b>12-17-55</b> , that I last saw the deceased alive on <b>12-17</b> , 19 <b>55</b> , and that death occurred at <b>6:05 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Dr. Beardsley</b>				ADDRESS (Street, city, town, state) <b>E. Church St. Salisbury, Maryland</b>		DATE SIGNED <b>Dec. 19 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec. 21, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>DEC 21 1955</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
JAMES TAYLOR		Male		35		Dec 21 1955		10:30 PM		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual occupation		16. Usual education		17. Usual marital status		18. Usual residence		19. Usual occupation		20. Usual education	
None		None		Married		Home		None		None		None		None		None		None	
21. Name of informant		22. Relationship		23. Address		24. Telephone		25. Signature of informant		26. Signature of registrar		27. Signature of physician		28. Signature of medical examiner		29. Signature of coroner		30. Signature of jury	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.

DEC 21 1955

RECEIVED

RECEIVED  
DIVISION OF HEALTH  
BALTIMORE, MARYLAND  
DEC 22 1955



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12517				12498			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Salisbury</u>		<u>5 years</u>		TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Delmar Blvd.</u>				STREET ADDRESS (If rural, give location) <u>Delmar Blvd.</u>			
3. NAME OF DECEASED: (First) <u>Claude</u>		(Middle) <u>Henry</u>		(Last) <u>Hopkins</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>21</u> (Year) <u>19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Unknown</u>		9. AGE last birthday: <u>59</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Brick laying</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Alexander W. Hopkins</u>				14. MOTHER'S MAIDEN NAME: <u>Sallie Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>W.W.L.</u>		(If Yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Mrs. Stingle Taylor, Fruitland, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						Sudden	
<u>916.0</u> Immediate cause (a) <u>Cremation</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home-trailer</u>		21c. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Maryland.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12 21 55 8P M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Trailer home caught on fire.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>12-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE/TIME OF <u>12/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		LOCATION City, town, or county (State) <u>Fruitland Maryland</u>	
DATE REC'D BY LOCAL REG <u>12-22-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Norman F. Baker</u>		ADDRESS <u>Hill &amp; Johnson Co, Salisbury, Maryland.</u>	

BUREAU V. S.

DEC 27 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12499

## 12518 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riverside Nursing Home</u>		STREET ADDRESS (If rural give location) <u>930 Second Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: <u>SALLIE E. JACKSON</u>		OF DEATH: <u>Dec. 24 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: day & month unk 1877
<u>Female</u>	<u>White</u>	<u>Widowed</u>	9. AGE last birthday <u>78</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
13. FATHER'S NAME: <u>Joeshiah Russell</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Beasley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs Mary Bundick Leemont, Virginia</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
151X IMMEDIATE CAUSE		(A) <u>Cardiac Failure</u>	
ANTECEDENT CAUSE (S):		(B) <u>Ca. of Stomach</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/1/55</u> , 19 <u>55</u> , to <u>12/24/55</u> , that I last saw the deceased alive on <u>12/24</u> , 19 <u>55</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. B. Smith</u>		ADDRESS <u>M.D. Mrs. Carter Salisbury</u>	
DATE SIGNED <u>12/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 26, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Remson Cemetery</u>		LOCATION (City, town, or county) (State) <u>RURAL Pocomoke, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-28-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
24. FUNERAL DIRECTOR <u>HENRY H. WATSON</u>		ADDRESS <u>Pocomoke, Maryland</u>	

STATE CERTIFICATE OF DEATH

RECEIVED  
DEC 30 1955  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12519

CERTIFICATE OF DEATH

Reg. Dist. No. 12544  
382

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		23X-2	
TOWN <u>Salisbury</u>				TOWN <u>Beth</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>177E2</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Florence Crawford Jennings</u>				OF DEATH: <u>December 25 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>June 1, 1884</u>	
9. AGE last birthday: <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>London, England</u>	
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>							
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>-</u>			
17. INFORMANT & ADDRESS: <u>Margaret Jennings, R. R. Berlin, Md</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
451X							
IMMEDIATE CAUSE (A) <u>Ruptured dissecting aneurysm</u>							
ANTECEDENT CAUSE (B) <u>4-5 days</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION: <u>none</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on <u>12-25, 1955</u> , and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. Fisher</u>				DATE SIGNED <u>12-25-55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)				24. FUNERAL DIRECTOR ADDRESS			
DATE REC'D BY LOCAL REGISTRAR <u>12-27-55</u>				REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>			
NAME OF CEMETERY OR CREMATORY <u>1007 Cemetery</u>				LOCATION (City, town, or county) (State) <u>Bishopville</u>			
DATE REC'D BY LOCAL REGISTRAR <u>12-27-55</u>				FUNERAL DIRECTOR ADDRESS <u>Peter Whaley, Sellersville, Del.</u>			

RECEIVED

DEC 29 1955

BUREAU V. S.



12520

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>310 Gay Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>James Marion Johnson</u>				<u>December 22 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Nov 17, 1902</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Fruit Brokers Express</u>		11. BIRTHPLACE (State or foreign country): <u>Hallwood Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>J. Drummond Johnson</u>				14. MOTHER'S MAIDEN NAME: <u>Bennie Bundick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Norman Johnson, Parksley Va.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchial pneumonia</u>							
DUE TO							
ANTECEDENT CAUSE (B) <u>Cancer of esophagus</u>						3 months	
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Oct 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Cancer of esophagus (low esophagus)</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/9</u> , 1955, to <u>12/22</u> , 1955, that I last saw the deceased alive on <u>12/21</u> , 1955, and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William H. Fisher, M.D.</u>				DATE SIGNED <u>12-22-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>12-24-55</u>		<u>Parksley Cemetery</u>		<u>Parksley, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12-29-55</u>		<u>Mary W. Holloman</u>		<u>J. W. Johnson</u>		<u>Parksley Va.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 2 1956

RECEIVED

12521

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PRINCESS ANNE</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>386 MARKEEN Avenue</u>			
3. NAME OF DECEASED: (First) <u>Alice</u>		(Middle)		(Last) <u>Jones</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>December 19 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>July 13, 1909</u>	
9. AGE last birthday <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Westover, Md</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Westover, Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Arthur William Jones</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Collins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS: <u>Arthur Jones</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular disease (med) wk</u>							
ANTECEDENT CAUSE (B) <u>Chronic glomerulonephritis</u>						yes?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>renal arteriosclerosis</u>						yes?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/13</u> , 1955, to <u>12/19</u> , 1955, that I last saw the deceased alive on <u>12/19</u> , 1955, and that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harry Matter</u>				ADDRESS <u>M.D. 711 Camden Ave, Salisbury, Md.</u>		DATE SIGNED <u>12/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>12-26-55</u>		<u>Revel's Neck Cemetery</u>		<u>Revel's Neck</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-20-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>		24. FUNERAL DIRECTOR <u>W. M. James</u>		ADDRESS <u>Princess Anne, Md</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 23 1955

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12522

## CERTIFICATE OF DEATH

12503

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Most of life</u>		STREET ADDRESS <u>119 First Street</u>		(If rural give location) <u>119 First Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - 119 First Street</u>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>William Alexander Jones</u>				<u>12 - 28 - 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L.W. Gunby Store</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico, Wicomico Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Weatherly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Bertha Brewington, 119 First St. Salisbury, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>				<u>Indefinite</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>19 Dec., 19 55</u> , to <u>28 Dec., 19 55</u> , that I last saw the deceased alive on <u>28 Dec., 19 55</u> , and that death occurred at <u>3:35</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Hurnell MD</u>				ADDRESS (Street, city, town, state) <u>608 W. Main Salisbury Md.</u> DATE SIGNED <u>30 Dec 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Quantico, Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 2 1955</u>		REGISTRAR'S SIGNATURE <u>Mary F. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u> ADDRESS <u>Funeral Home Salisbury Md.</u>			





12523

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Washington St</u>		✓	
3. NAME OF DECEASED: (First) <u>George</u> (Middle) <u>Littleton</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 16, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		8. DATE OF BIRTH: <u>Oct 13, 1899</u>		9. AGE last birthday <u>76</u> yrs. <u>2</u> Months <u>3</u> Days <u></u> Hours <u></u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <u>Retired Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Furniture Store</u>		11. BIRTHPLACE (State or foreign country): <u>Powellville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Louise Littleton</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS: <u>Mrs. Edna M. Littleton, Snow Hill, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Degenerative Heart Disease</u>						<u>unknown</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Coronary Arteriosclerosis</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Coronary Arteriosclerosis</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-7-55</u> , 1955, to <u>12-16-55</u> , 1955; that I last saw the deceased alive on <u>12-16-55</u> , 1955, and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. Ellis, Jr.</u>		ADDRESS <u>Salisbury Md.</u>		DATE SIGNED <u>12-16-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>12-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Whitcoat Cemetery</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-17-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		FUNERAL DIRECTOR <u>Ray E. Dennis</u>		ADDRESS <u>Snow Hill, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 21 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12524

## CERTIFICATE OF DEATH

12505

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		TOWN <u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Spring Hill Sanitarium</u>				STREET ADDRESS (If rural give location) <u>MAIN ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ANDASIA ROBINS MAYNARD</u>				<b>4. DATE OF DEATH</b> (Month) <u>Dec.</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>JAN 19, 1868</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired R. Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>DR. FRANCIS HENRY PURNELL</u>				14. MOTHER'S MAIDEN NAME <u>SARAH ANNE TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>MISS. NANNIE PURNELL, BERLIN MD</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>442X</u> IMMEDIATE CAUSE (A) <u>Cardio-vascular renal disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>12/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Theresa Tush</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>12-2-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
24. REC'D BY REGISTRAR <u>DEC 5 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burby</u>		ADDRESS <u>Berlin Md</u>	

# CERTIFICATE OF DEATH

1955

1. USUAL RESIDENCE HOME OR BOARDING

Worcester Mo

Berlin

MAIN ST

Jan 19, 1958

Berlin Mo

Dr Francis Henry Furness

No

No

No

Star Anna Taylor

BUREAU V. S.

DEC 5 1955

RECEIVED

ST PAUL

12/3/55

Berlin

INSTRUCTIONS

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12535

## CERTIFICATE OF DEATH

12506

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>404 W. College Ave</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Jennette</u> <u>Means</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December</u> <u>25</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>December 25, 1955</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jennette Bryan Means</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Theresa Holland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Jennings Bryan Means, Mother</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
176X IMMEDIATE CAUSE (A) <u>Incubated</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Life</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/25/55</u> , 19 <u>55</u> , to <u>12/25/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/25/55</u> , 19 <u>55</u> , and that death occurred at <u>10 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Walter Christensen</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>12-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Md.</u>	
24. REC'D BY REGISTRAR DATE <u>12-27-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	

DEC 29 1955

RECEIVED

BUREAU V. S.



12526

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>DELAWARE</u> COUNTY <u>SUSSEX</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>SALISBURY</u>				TOWN <u>MILLSBORO</u>		<u>46 x -3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>Baldwin</u>		(Middle) <u>B</u>		(Last) <u>MOORE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>December 6 1955</u>	
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Nov. 29-1886</u>		8. AGE last birthday <u>69</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Joseph Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Rachel Rogers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>9</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mrs. Martha Moore, Millsboro, Del</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>						<u>36 hrs.</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-6</u> , 1955, to <u>12-6</u> , 1955, that I last saw the deceased alive on <u>12-6</u> , 1955, and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>		ADDRESS <u>Salisbury, Md.</u>		DATE SIGNED <u>12-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mechanic Cemetery</u>		LOCATION (City, town, or county) (State) <u>Millsboro - Del.</u>	
OATE REC'D BY LOCAL REGISTRAR <u>12-7-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Wm Howard Wells - Pottomac, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 9 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12527

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12508  
Reg. Dist.

No. 332

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Salisbury</u>		<u>life</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Tony Tank Manor</u>				STREET ADDRESS (If rural, give location) <u>Tony Tank- Clyde Ave.</u>			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>John Charles</u> <u>Mumper</u>				<u>12-</u> <u>24</u> <u>19 55</u>			
<b>5. SEX:</b>	<b>6. COLOR OR RACE:</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b>	<b>8. DATE OF BIRTH:</b>	<b>9. AGE last birthday:</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>M</u>	<u>W</u>	<u>S</u>	<u>Sept. 2, 1945</u>	<u>10</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>Child</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>Child</u>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Pennsylvania</u>	
<b>13. FATHER'S NAME:</b> <u>David M. Mumper</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Anna Rockey</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY No.:</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>David M. Mumper-Clyde Ave. Salisbury, Md</u>			

<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<p><u>929.8</u></p> <p><b>Immediate cause</b> (a) <u>Drowning</u></p> <p style="text-align: center;">DUE TO</p> <p><b>Antecedent cause(s)</b> (b) _____</p> <p>Diseases or conditions, if any, giving rise to the above cause <b>DUE TO</b></p> <p>stating underlying cause last (c) _____</p>						<u>Sudden</u>	
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>					
_____		_____					
<b>21a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/>		<b>21b. PLACE</b> (Home, farm, factory, street, office bldg., etc.)		<b>21c. (City or town)</b>		<b>(County)</b>	
CAUSE OF DEATH.		OF INJURY <u>Tony tank lake</u>		<u>Salisbury</u>		<u>Wicomico Maryland</u>	
<b>21d. TIME</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
OF INJURY <u>12 24 55</u> M.		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<u>Fell through ice on lake.</u>			
<p><b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b></p> <p><b>SIGNATURE</b> <u>David M. Mumper</u></p> <p style="text-align: right;">M. D. <u>12-26-55</u></p>							
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>12-27-55</u>		<u>Wicomico Memorial Park</u>		<u>Salisbury, Maryland</u>	
<b>DATE REC'D BY LOCAL REG.</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>24. FUNERAL DIRECTOR</b>		<b>ADDRESS</b>	
<u>12-27-55</u>		<u>Mary W. Holloman</u>		<u>Thomas F. Wallace</u>		<u>Salisbury, Md.</u>	

RECEIVED

DEC 30 1955

BUREAU V. S.

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12528

CERTIFICATE OF DEATH

12509

Dr. Harry Mattox

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Delmar</b>		COUNTY <b>Sussex</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <b>Salisbury</b>				TOWN <b>Delmar</b>		46X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>Jewell St.</b>			
3. NAME OF DECEASED (First) (Middle) (Last) <b>ELLA VIRGINIA PARKS</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>DEC. 24 th 19 55</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Dec. 26, 1881</b>	
9. AGE last birthday <b>73</b> yrs.		IF UNDER 1 YEAR <b>11</b> Months		IF UNDER 24 HRS. <b>28</b> Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Nanticoke, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Alphens Rencher</b>				14. MOTHER'S MAIDEN NAME <b>Annie Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS <b>Mr. Luther M. Parks (Son) Swanwyck Gardens, New Castle, Delaware</b>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) <b>Diabetic Acidosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Diabetic mellitus</b>				years.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12/23</b> , 19 <b>55</b> , to <b>12/24</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>12/24</b> , 19 <b>55</b> , and that death occurred at <b>6:00 A</b> .M., from the causes and on the date stated above.							
SIGNATURE <b>Harry Mattox</b>				ADDRESS (Street, city, town, state) <b>M.D. Camden Ave. Salisbury, Maryland</b>			
DATE <b>Dec. 28 1955</b>				DATE SIGNED <b>Dec. 27 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Dec. 28, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>EG 28 1955</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	

RECEIVED



## 12529 CERTIFICATE OF DEATH

12510

332

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Salisbury P. Z. D.</u>		LENGTH OF STAY (in this place) <u>3 months</u>		CITY OR TOWN <u>Salisbury P. Z. D. #5-X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Hermon Road.</u>				STREET ADDRESS (If rural, give location) <u>Mt. Hermon Road.</u>			
3. NAME OF DECEASED (Type or Print) <u>Irene Virginia Parsons</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 28, 1896.</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	11. BIRTHPLACE (State or foreign country) <u>Newark Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi Bradford</u>				14. MOTHER'S MAIDEN NAME <u>Lula Hester Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes) <u>No</u> (or, unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Margaret M. Evans (Daughter)</u> <u>R.D. #5 Quantico Rd. Salisbury, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u> (C) <u>arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>				?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11/30</u>		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/15</u> , 19 <u>55</u> , to <u>death</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>55</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ernest M. Lammie</u> M.D.				ADDRESS (Street, city, town, state) <u>100 Grove St Delmar Del</u> DATE SIGNED <u>12/3/55</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 6. 55.</u>		NAME OF CEMETERY OR CREMATORY <u>Melsons Cemetery.</u>		LOCATION (City, town, or county) <u>R.D. Delmar, Maryland.</u> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway &amp; Co. Salisbury, Maryland.</u> ADDRESS			
DATE <u>7 1955</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# MARIANA STATE DEPARTMENT OF HEALTH - BATHING

## CERTIFICATE OF DEATH

Page 1001-1002

1. Name of deceased (Print name in full)

2. Sex (Male or Female)  
 3. Age (Years and months)  
 4. Date of birth (Month, day, year)  
 5. Place of birth (City, State, Country)  
 6. Occupation (Print name of occupation)

7. Cause of death (Print name of disease or injury)  
 8. Date of death (Month, day, year)  
 9. Place of death (City, State, Country)

10. Name of physician (Print name in full)  
 11. Name of hospital (Print name in full)

12. Name of funeral home (Print name in full)  
 13. Name of cemetery (Print name in full)

14. Name of informant (Print name in full)  
 15. Name of informant (Print name in full)

16. Name of informant (Print name in full)  
 17. Name of informant (Print name in full)

18. Name of informant (Print name in full)  
 19. Name of informant (Print name in full)

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64. Name of informant (Print name in full)  
 65. Name of informant (Print name in full)

BUREAU V. S.

DEC 7 1955

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1001-1002

1001-1002

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12511

12530 **CERTIFICATE OF DEATH**

Dr. Harry Mattox

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hosp.</b>				STREET ADDRESS (If rural give location) <b>E. Williams St</b>			
<b>3. NAME OF DECEASED</b> (First) <b>RAYMOND</b> (Middle) <b>PARSONS</b> (Last)				<b>4. DATE OF DEATH</b> (Month) <b>DEC.</b> (Day) <b>17</b> (Year) <b>19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>June 4 1894</b>		<b>9. AGE last birthday</b> <b>61</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Chicken Grower</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Chicken</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Salisbury, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John B. Parsons</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sallie M. Parsons</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>W.V.# 1</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Franklin Ehinger - 639 Homer St. Salisbury, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>331X IMMEDIATE CAUSE (A)</b> <b>Bronchopneumonia</b>						<b>2 days</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Cerebral Thrombosis</b>						<b>2 wks</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>arteriosclerosis</b>						<b>10 yrs.</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 12/6, 1955, to 12/17, 1955, that I last saw the deceased alive on 12/17, 1955, and that death occurred at 7:00 AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>H. Mattox</b>				<b>DATE SIGNED</b> <b>ADDRESS (Street, city, town, state)</b> <b>M.D. Camden Ave. Salisbury, Maryland Dec. 19 1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Dec 20, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>DEC 21 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b> <b>ADDRESS</b> <b>SALISBURY MARYLAND</b>			

# 1955 CERTIFICATE OF DEATH

Part 1. General Information

Part 2. Cause of Death

1. Name of Deceased

2. Date of Death

3. Sex

4. Age

5. Race

6. Place of Birth

7. Date of Birth

8. Usual Residence

9. Date of Admission to Hospital

10. Date of Discharge

11. Date of Death

12. Place of Death

13. Date of Death

14. Date of Death

15. Date of Death

16. Date of Death

17. Date of Death

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39. Date of Death

1. Name of Deceased

2. Date of Death

3. Sex

4. Age

5. Race

6. Place of Birth

7. Date of Birth

8. Usual Residence

9. Date of Admission to Hospital

10. Date of Discharge

11. Date of Death

12. Place of Death

13. Date of Death

14. Date of Death

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35. Date of Death

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DEC 21 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12552  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12512  
 No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Hebron</u>		<u>6 yrs.</u>		TOWN <u>Hebron</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R F D # 1</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Harry Raymond Pierson</u>				<u>12 17 19 55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>July 23, 1889</u>	9. AGE last birthday: <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>	11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Thomas R. Peirson</u>				14. MOTHER'S MAIDEN NAME: <u>Anna C. Poist</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Leslie Pierson, Oxford, Pa.</u>			
		(If Yes, give war or dates of service)					
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary artery disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death results from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Byrge</u>		CHIEF MEDICAL EXAMINER		DATE SIGNED			
		DEPUTY MEDICAL EXAMINER					
		M. D. ASSISTANT MEDICAL EXAM.		<u>12 20 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12-21-55</u>		NAME OF CEMETERY OR CREMATORY: <u>NEW LONDON CEMETERY</u>		LOCATION (City, town, or county) (State): <u>NEW LONDON, PENNA.</u>	
DATE RECD BY LOCAL REGISTRY: <u>12-20-55</u>		REGISTRAR'S SIGNATURE: <u>Marjorie H. Halloway</u>		24. FUNERAL DIRECTOR: <u>Thomas F. Wallace</u>		ADDRESS: <u>Salisbury, Md.</u>	

BUREAU V. S.

DEC 23 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12531

12513

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Salisbury</u>		<u>life</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>147 Delaware Ave.</u>				STREET ADDRESS (If rural, give location) <u>147 Delaware Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>Mabel Anne Pinkett</u>				<u>12 10 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>F</u>		<u>C</u>				<u>Nov. 14, 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>infant</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Felix Winder</u>				14. MOTHER'S MAIDEN NAME: <u>Monterey Pinkett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Monterey Pinkett, 147 Del. St. Salisbury, Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							hours
<u>763.0</u> Immediate cause (a) <u>Broncho-pneumonia</u> DUE TO Antecedent cause(s) Diseases or conditions, if any, (b) _____ giving rise to the above cause DUE TO stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>12-13-55</u>				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>12-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>12-13-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Stewart Funeral Home, Salisbury, Md.</u> ADDRESS			

20X5182363

BUREAU V. S.

DEC 16 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12514

## 12532 CERTIFICATE OF DEATH

Dr. Gray

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>12</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		TOWN <b>Salisbury</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>685 Fitzwater St</b>				STREET ADDRESS (If rural give location) <b>685 Fitzwater St</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>ELIZABETH MAY RATCLIFFE</b>				<b>4. DATE OF DEATH</b> (Month) <b>DEC.</b> (Day) <b>29</b> th (Year) <b>19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Apr. 17, 1872</b>	<b>9. AGE last birthday</b> <b>83</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>29</b> Days <b>th</b>	<b>IF UNDER 24 HRS.</b> Hours <b>55</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Kentucky</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Albert Newton Jett</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sallie Price</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S ADDRESS</b> <b>Kathlyn Rahoe McDaniel-685 Fitzwater St Salisbury, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>332X IMMEDIATE CAUSE (A)</b> <b>Cardiac Failure</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 hrs</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Cerebral Thrombosis</b>				<b>3 wk</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <b>M.</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from May 19 53, to Dec 24, 19 55, that I last saw the deceased alive on Dec 29, 19 55, and that death occurred at 5:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>William H. Gray</i>				<b>DATE SIGNED</b> <b>ADDRESS (Street, city, town, state)</b> <b>M.D. Camden Ave. Salisbury, Maryland Dec. 30 1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Jan. 1, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>JAN 2 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			

# CERTIFICATE OF DEATH

FILE NO. 12

DATE OF DEATH

<p>1. Name of Deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of Birth</p>		<p>5. Place of Birth</p>		<p>6. Usual Residence</p>		<p>7. Cause of Death</p>		<p>8. Manner of Death</p>		<p>9. Signature of Physician</p>		<p>10. Signature of Registrar</p>	
<p>11. Name of Informant</p>		<p>12. Relationship</p>		<p>13. Address</p>		<p>14. City</p>		<p>15. State</p>		<p>16. Zip</p>		<p>17. Date of Report</p>		<p>18. Signature of Informant</p>		<p>19. Signature of Registrar</p>		<p>20. Signature of Physician</p>	

BUREAU V. S.

JAN 2 1956

RECEIVED

**INSTRUCTIONS**

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12533

**CERTIFICATE OF DEATH**

12515

Items 13,14 Film 190 12-16-55 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Salisbury</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Edgemont Avenue</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Revelle</u>				<u>December 5</u> 19 <u>55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<u>F</u>	<u>W</u>	<u>Newborn</u>	<u>12-5-55</u>			<u>1</u> <u>15</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
				<u>Maryland</u>		<u>U. S. A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>William Revelle</u>				<u>Margaret Whedbee</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>773.5 IMMEDIATE CAUSE (A)</b>						<u>Respiratory Failure</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)</b>						<u>Prematurity</u>	
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>12/5</u>, 19 <u>55</u>, to <u>12/7</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>12/5</u>, 19 <u>55</u>, and that death occurred at <u>4:00 P.M.</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>William C. Morgan</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury Md</u>		<b>DATE SIGNED</b> <u>12/6/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Cremation</u>		<u>12/7/55</u>		<u>Peninsula General Hospital</u>		<u>Salisbury Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>12-7-55</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>			

2 V 5313390

# CERTIFICATE OF DEATH

1855

Form No. 1-15

PLACE OF DEATH

NAME OF DECEASED

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

CAUSE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

BUREAU V. S.

DEC 9 1955

RECEIVED

EXHIBIT

OFFICE OF THE ATTORNEY GENERAL  
BALTIMORE, MARYLAND



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12534 CERTIFICATE OF DEATH

12516

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>Md.</b>		COUNTY <b>Wicomico</b>		STATE <b>Md.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		STREET ADDRESS (If rural give location) <b>Church St.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula General Hospital</b>				STREET ADDRESS (If rural give location) <b>Church St.</b>			
3. NAME OF DECEASED (Type or Print) <b>Norris A. Riffin</b>				4. DATE OF DEATH <b>Dec. 23 1955</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, or SEPARATED <b>married</b>		8. DATE OF BIRTH <b>Oct. 23, 1925</b>	
9. AGE last birthday <b>30</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Filling station attendant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
13. FATHER'S NAME <b>Arch Riffin</b>				14. MOTHER'S MAIDEN NAME <b>Ina F. Long</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>yes</b> <b>war II</b>				16. SOCIAL SECURITY NO. <b>218-20-3009</b>			
17. INFORMANT & ADDRESS <b>Miss Elise Riffin Park Ave Apt. Salisbury, Maryland</b>				18. MEDICAL CERTIFICATION <b>Salisbury, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <b>Fracture Lower Jaw Both Sides</b>				<b>5 hrs</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Fracture Nose &amp; Right Clavicle</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Crushed Chest-Internal Hemorrhage and Shock</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, or INJURY street, office, bldg., etc.) <b>Princess Anne Rd</b>			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>Princess Anne Md</b>				21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>Dec 23-1955 4:55 P M.</b>			
21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR? <b>Car accident</b>			
22. I hereby certify that I attended the deceased from <b>after death</b> on <b>Dec 24</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Dec 24</b> , 19 <b>55</b> , and that death occurred at <b>10:22 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Dr. John M. Lafely Medical Examiner</b>				ADDRESS (Street, city, town, state) <b>Princess Anne Md</b>			
DATE SIGNED <b>Dec 26-55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				DATE THEREOF <b>12-26-1955</b>			
NAME OF CEMETERY OR CREMATORY <b>Perryhawkin cemetery</b>				LOCATION (City, town, or county) (State) <b>Near Princess Anne, Md.</b>			
24. REC'D BY REGISTRAR <b>12-28-55</b>				25. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>			
REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>				ADDRESS <b>Princess Anne, Maryland</b>			

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BUREAU V. S.

DEC 30 1955

RECEIVED

LEVIN, R. WILSON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

12535

12517

1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Delaware</u> COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Millsboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>467-3</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>J.</u> (Middle) <u>Rose</u> (Last)		4. DATE OF DEATH <u>December 6, 1955</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, X, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Apr. 24, 1892</u>
9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days Hours Min.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unit agent</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Phil Rose - Millsboro - Del.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Myocardial infarct</u>		12 days	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-24</u> , 19 <u>55</u> , to <u>12-6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-6</u> , 19 <u>55</u> , and that death occurred at <u>7:45</u> a.m., from the causes and on the date stated above.			
SIGNATURE <u>William R. Ellis, Jr. M.D.</u>		ADDRESS <u>Salisbury, Md.</u>	
DATE SIGNED <u>12-6-55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/9/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Wicomico Cemetery</u>		LOCATION (City, town, or county) <u>Millsboro - Del.</u>	
DATE REC'D BY LOCAL REG. <u>12-7-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u>	
FUNERAL DIRECTOR <u>Wm Howard Wells Pittenille</u>		ADDRESS <u>Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 9 1955

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12536

## CERTIFICATE OF DEATH

12518

Reg. Dist. No. 337

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>MARDELA SPRINGS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Charles</u> (First) <u>J</u> (Middle) <u>Rybak</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>December</u> (Day) <u>3</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>married</u>	<b>8. DATE OF BIRTH</b> <u>June 21-1886</u>		<b>9. AGE last birthday</b> <u>69</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cloth Spangier</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>F. J. Hanssard</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Balto Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Rybak</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-07-5341</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Balto 20. Section Rd. 12 Melvin C Rybak Box 658, Navy</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>199.9 IMMEDIATE CAUSE</b> <u>Metastatic Carcinoma of Liver</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>unknown</u>	
<b>ANTECEDENT CAUSE(S)</b> <u>Due to</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> <u>undernourished</u>							
<b>STATING UNDERLYING CAUSE LAST</b> <u>Due to</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>12-3</u> , 19 <u>55</u> , <b>to</b> <u>12-3</u> , 19 <u>55</u> , <b>that I last saw the deceased alive on</b> <u>12-3</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>7 P.</u> <b>M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>William B. Ellis Jr.</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury Md.</u>		<b>DATE SIGNED</b> <u>12-3-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12/5/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Holy Redeemer Cen</u>		<b>LOCATION</b> (City, town, or county) <u>Balto Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Jessamine Funeral Home</u>		<b>ADDRESS</b> <u>7401 Belair Rd.</u>	
<b>DATE</b> <u>DEC 6 1955</u>							

# CERTIFICATE OF DEATH

1955

DEATH NUMBERED HOME OF DECEASED

MARYLAND

LOCALITY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF DEPARTURE FROM STATE

DATE OF RETURN TO STATE

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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BUREAU V. S.

DEC 6 1955

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12540

12537

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH - COUNTY <u>Wisconsin</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Del.</u> COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury</u>				TOWN <u>Whiterville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gen. General</u>				STREET ADDRESS <u>46 X 3</u>	
3. NAME OF DECEASED (Type or Print) <u>William James Schevel Jr.</u>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>December 28 1955</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	
8. DATE OF BIRTH <u>12/21/55</u>		9. AGE last birthday <u>7</u> yrs. If under 1 year Months Days Hours Min.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Del.</u>	
13. FATHER'S NAME <u>William J. Schevel</u>		14. MOTHER'S MAIDEN NAME <u>Willa Kiesel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Wm. J. Schevel - Salisbury</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		7593 Immediate cause (a) <u>Pulmonary Stenosis - multiple other congenital defects including clubbed feet and hands + aortic of lars (3) Pneumothorax, r+, congenital</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
Antecedent cause(s) (b) <u>Clubbed feet and hands + aortic of lars (3) Pneumothorax, r+, congenital</u>		(c)			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12/28/55</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/21/55</u> , 19 <u>55</u> , to <u>12/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/28</u> , 19 <u>55</u> and that death occurred at <u>9:15 a.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Robert H. Saunders</u>		(Degree or title) <u>MD 926 H-Division St Salisbury</u>		DATE SIGNED <u>12/29/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>	
LOCATION (City, town, or county) <u>Whiterville - Del.</u>		(State)		24. FUNERAL DIRECTOR <u>Ann Howard Wells - Pittsville</u>	
DATE REC'D BY LOCAL REG. <u>12-29-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		ADDRESS <u>Pittsville</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 2 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12521

12538

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (in this place) <u>5 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL Hospital</u>		STREET ADDRESS (If rural give location) <u>315 New York Ave.</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Richard BRINSLEY Sheridan SR.</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 9<sup>th</sup> 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 10, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Outdoor Advertiser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Advertisers</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Sheridan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mellinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-20-5567 -A</u>		17. INFORMANT & ADDRESS <u>R.B. Sheridan, Jr. Same</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE (A) Coronary Artery Thrombosis</u>				<u>4 days</u>			
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Coronary Atherosclerosis</u>							
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 5, 1955</u> to <u>Dec 9, 1955</u> , that I last saw the deceased alive on <u>Dec 9, 1955</u> , and that death occurred at <u>4:29 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David J. Silvers</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md. Dec 9, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>DEC 13 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>		ADDRESS <u>The Hill &amp; Johnson Co. Salisbury, Md.</u>	

RECEIVED

DEC 18 1955

BUREAU V. S.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

155-1

155-1

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, but not later than 48 hours after death. It should be filled out in the presence of the deceased's family or other persons who are familiar with the deceased's condition. It should be filled out in the presence of the deceased's family or other persons who are familiar with the deceased's condition. It should be filled out in the presence of the deceased's family or other persons who are familiar with the deceased's condition.

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12539

CERTIFICATE OF DEATH

12522

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		LENGTH OF STAY (in this place) <u>6 mo. 18 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		TOWN <u>1939-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Harriett P. Slaughter</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 11 19 55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>June 12, 1874</u>		<b>9. AGE last birthday</b> <u>81</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>unk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>unk</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Smith Horsey</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Milky Sterling</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>unk</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unk</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>15. MEDICAL CERTIFICATION</b>			
<b>331X</b> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis General</u>				<u>unk</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Hypertensive Arteriosclerotic Cardiovascular disease</u>				<u>unk</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>May 23, 19 55</u>, to <u>Dec. 11, 19 55</u>, that I last saw the deceased alive on <u>Dec. 11, 19 55</u>, and that death occurred at <u>9:00A</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Dr. V. Guerman</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury, Maryland</u>			
<b>DATE THEREOF</b> <u>Dec 14-55</u>				<b>DATE SIGNED</b> <u>Dec. 11, 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Lansonia</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Crisfield Somerset Md</u>			
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles H. Ward Mason Md.</u>			
<b>DATE</b> <u>DEC 19 1955</u>							

# CERTIFICATE OF DEATH

Form 10-1-54

1. Name of deceased (Print or write)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of cremation

20. Signature of other

21. Signature of other

22. Signature of other

23. Signature of other

24. Signature of other

25. Signature of other

26. Signature of other

27. Signature of other

28. Signature of other

29. Signature of other

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32. Signature of other

33. Signature of other

34. Signature of other

35. Signature of other

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37. Signature of other

38. Signature of other

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51. Signature of other

52. Signature of other

53. Signature of other

54. Signature of other

55. Signature of other

56. Signature of other

57. Signature of other

BUREAU V. S.

DEC 19 1955

RECEIVED

EXHIBITION

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS. IT IS NOT TO BE LOANED, COPIED, OR REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS TO BE DESTROYED AFTER THE EXPIRATION OF THE TERM OF YEARS SPECIFIED IN THE ACT. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS. IT IS NOT TO BE LOANED, COPIED, OR REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS TO BE DESTROYED AFTER THE EXPIRATION OF THE TERM OF YEARS SPECIFIED IN THE ACT.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12540

## CERTIFICATE OF DEATH

12523

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>1 Yr.</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff Rd.,</u>				STREET ADDRESS (If rural give location) <u>Pine Bluff Rd.,</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ELIZABETH</u> (Middle) <u>CATHERINE</u> (Last) <u>TAYLOR</u>				(Month) <u>12</u> (Day) <u>30</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 19, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
							Min.
10a. USUAL OCCUPATION (Give kind of work done during most of business life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Rau</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Hetzer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mr. O.C. Taylor, Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>170X Metastatic Ca of Lung</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Breast Adenocarcinoma</u>				<u>thru</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30</u> , 19 <u>55</u> , to <u>Dec 31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/30</u> , 19 <u>55</u> , and that death occurred at <u>11:20</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William H. Gray, M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>		ADDRESS	
DATE <u>JAN 5 1956</u>							

# CERTIFICATE OF DEATH

1. Name of Deceased Eugene White		2. Sex Male		3. Age 48	
4. Date of Death Nov 15, 1956		5. Time of Death 11:00 AM		6. Place of Death Home	
7. Cause of Death Heart Disease		8. Manner of Death Natural		9. Signature of Physician [Signature]	
10. Signature of Registrar [Signature]		11. Date of Registration Nov 16, 1956		12. Office of Registrar Baltimore, Md.	

BUREAU V. 2

IAN 5 1956

RECEIVED

The J. J. & W. J. Company, Inc.  
Baltimore, Md.

NOTICE: This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md. It is to be retained for a period of ten years after the date of death.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12541

## CERTIFICATE OF DEATH

12524

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Delmar</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Gen. Hospital</u>				STREET ADDRESS <u>Elizabeth</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Ernest G. Taylor</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 21 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <del>SINGLE, MARRIED,</del> <u>WIDOWED, DIVORCED,</u> (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 17, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired) <u>Bridge Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Noami Ross.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-01-7180</u>		17. INFORMANT & ADDRESS <u>Wm. E. Taylor, Salisbury, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
4437 IMMEDIATE CAUSE (A) <u>Extending Cardio-Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C.V. Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/10</u> , 19 <u>55</u> , to <u>12-21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-21</u> , 19 <u>55</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. B. Smith</u>		M.D. <u>RT 2 Salisbury</u>		ADDRESS (Street, city, town, state) <u>12-24-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATION <u>Mt Olive</u>		LOCATION (City, town, or county) (State) <u>Delmar, Delaware</u>	
24. REC'D BY REGISTRAR DATE <u>DEC 20 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Delmar, Del.</u>		ADDRESS	

# CERTIFICATE OF DEATH

Ref. No. 14

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF MINISTER

18. SIGNATURE OF RABBI

19. SIGNATURE OF PRIEST

20. SIGNATURE OF BISHOP

21. SIGNATURE OF ARCHBISHOP

22. SIGNATURE OF PAPAL LEGATE

23. SIGNATURE OF APOSTOLIC NUNCIUS

24. SIGNATURE OF VICE-LEGATE

25. SIGNATURE OF CHANCELLOR

26. SIGNATURE OF SECRETARY

27. SIGNATURE OF CLERK

28. SIGNATURE OF DEPUTY CLERK

29. SIGNATURE OF ASSISTANT CLERK

30. SIGNATURE OF JUNIOR CLERK

31. SIGNATURE OF STENOGRAPHER

32. SIGNATURE OF TYPEWRITER

33. SIGNATURE OF RECEPTIONIST

34. SIGNATURE OF MAIL ROOM

35. SIGNATURE OF TELEPHONE ROOM

36. SIGNATURE OF RECORDS ROOM

37. SIGNATURE OF GENERAL OFFICE

38. SIGNATURE OF CHIEF OF BUREAU

39. SIGNATURE OF DEPUTY CHIEF

40. SIGNATURE OF ASSISTANT CHIEF

41. SIGNATURE OF CLERK IN CHARGE

42. SIGNATURE OF DEPUTY CLERK IN CHARGE

43. SIGNATURE OF ASSISTANT CLERK IN CHARGE

44. SIGNATURE OF JUNIOR CLERK IN CHARGE

45. SIGNATURE OF STENOGRAPHER IN CHARGE

46. SIGNATURE OF TYPEWRITER IN CHARGE

47. SIGNATURE OF RECEPTIONIST IN CHARGE

48. SIGNATURE OF MAIL ROOM IN CHARGE

49. SIGNATURE OF TELEPHONE ROOM IN CHARGE

50. SIGNATURE OF RECORDS ROOM IN CHARGE

51. SIGNATURE OF GENERAL OFFICE IN CHARGE

52. SIGNATURE OF CHIEF OF BUREAU IN CHARGE

53. SIGNATURE OF DEPUTY CHIEF IN CHARGE

54. SIGNATURE OF ASSISTANT CHIEF IN CHARGE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF MINISTER

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52. SIGNATURE OF CHIEF OF BUREAU IN CHARGE

53. SIGNATURE OF DEPUTY CHIEF IN CHARGE

54. SIGNATURE OF ASSISTANT CHIEF IN CHARGE

BUREAU V. B.

JEC 28 1955

RECEIVED

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESSES  
13. SIGNATURE OF DECEASED  
14. SIGNATURE OF NEXT OF KIN  
15. SIGNATURE OF BURIAL OFFICIAL  
16. SIGNATURE OF CHURCH OFFICIAL  
17. SIGNATURE OF MINISTER  
18. SIGNATURE OF RABBI  
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52. SIGNATURE OF CHIEF OF BUREAU IN CHARGE  
53. SIGNATURE OF DEPUTY CHIEF IN CHARGE  
54. SIGNATURE OF ASSISTANT CHIEF IN CHARGE

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12553

## CERTIFICATE OF DEATH

12525

Reg. Dist. No. 932

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Quantico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
TOWN <u>Quantico</u>		<u>All life</u>		<u>Box 206</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - Quantico</u>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Joshua Handy Taylor</u>				<u>12</u> <u>21</u> - <u>19</u> <u>55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>A.A.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>1883</u>	
9. AGE last birthday <u>72</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fired Steam Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico, Wicomico Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joshua H. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cottman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-05-4371</u>		17. INFORMANT & ADDRESS <u>Mrs. Octavia Taylor, Quantico, Md.</u>	
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Myocardial infarct</u>						<u>1 hour 30 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary occlusion</u>						<u>1 hour 30 min.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary arteriosclerosis</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis generalized + Hypertension</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>enlarged</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-27-55</u> to <u>12-27-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-10-55</u> , 19 <u>55</u> and that death occurred at <u>10:17</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Baltimore Md.</u>		DATE SIGNED <u>12-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE-THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Quantico Cemetery</u>		LOCATION (City, town, or county) (State) <u>Quantico, Wicomico Co., Md.</u>	
24. REC'D BY REGISTRAR <u>12-27-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary J. Stewart</u> ADDRESS <u>Funeral Home - Salisbury Md.</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



DEC 29 1955

RECEIVED



12542

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		4 days		OR TOWN <u>Pocomoke</u>		23-42-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 341</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
David Tyler				OF DEATH: December 21 1955			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, specify if retired) <u>Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>George Tyler</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ann</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS: <u>Leon Lawrence, Jr. Pocomoke, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Postoperative Hemorrhage from Gastric Ulcer</u>						3 days	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Perforated Gastric Ulcer</u>						6 days.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis with Arteriosclerotic Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>12-16-55</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Perforated Gastric Ulcer</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-16</u> , 1955, to <u>12-21</u> , 1955, that I last saw the deceased alive on <u>12-21</u> , 1955, and that death occurred at <u>2:10 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Bayanes</u>				ADDRESS <u>M.D. 222 N. Division St., Salisbury, Md.</u>		DATE SIGNED <u>12-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-23-55</u>		<u>Baptist Cemetery</u>		<u>Pocomoke, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12-22-55</u>		<u>Mary W. Holloman</u>		<u>Henry A. Watson</u>		<u>Pocomoke, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 27 1955

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12527

12543

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>4 Wks</u>		OR TOWN <u>Salisbury</u>		OR TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Gaskill Apts.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>HELEN</u> (First) <u>ULMAN</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>12</u> (Day) <u>12</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 28, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Own Movie Theater</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Theater</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Ulman</u>				14. MOTHER'S MAIDEN NAME <u>Lena Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-10-9467</u>		17. INFORMANT & ADDRESS <u>Mr. Bernard Ulman Sr., Baltimore, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
442X IMMEDIATE CAUSE (A) <u>Cardiovascular renal disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____				_____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____				_____			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				_____			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>12-12</u> , 19 <u>55</u> , to <u>12-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-12</u> , 19 <u>55</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above.				22. I hereby certify that I attended the deceased from <u>12-12</u> , 19 <u>55</u> , to <u>12-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-12</u> , 19 <u>55</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Thelma J. Jolley</u>		M.D. <u>Salisbury Md</u>		ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>12-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Oheb Shalom Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) _____	
24. REC'D BY REGISTRAR <u>DEC 16 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>		ADDRESS <u>The Hill &amp; Johnson Co. Salisbury, Md.</u>	

CERTIFICATE OF DEATH

Reg. Ord. No.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

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BUREAU V. S.

DEC 16 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12544

## CERTIFICATE OF DEATH

12528

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>20 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula General Hospital</b>		STREET ADDRESS (If rural give location) <b>157 Delaware Ave.</b>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Paige Christopher Wainwright</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>12 - 28 - 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>A.A.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>6-5-1891</b>	<b>9. AGE last birthday</b> <b>64 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>6</b> Days <b>23</b>	<b>IF UNDER 24 HRS.</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Read's Drug Store</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>White Haven, Wicomico Co.Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Noah Wainwright</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Long</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-07-8482</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Salisbury, Maryland</b> <b>Mrs. Laura Wainwright, 157 Del. Ave.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.0 IMMEDIATE CAUSE (A)</b> <b>Confestive Heart Failure</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arterio-sclerotic Heart Disease</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Arterio-sclerotic &amp; Hypertension</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Dec 14, 19 55</u>, to <u>Dec 28, 19 55</u>, that I last saw the deceased alive on <u>Dec 28, 19 55</u>, and that death occurred at <u>2 26 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Carrie L. H. Can</b>				<b>ADDRESS (Street, city, town, state)</b> <b>226 N. Alameda</b>		<b>DATE SIGNED</b> <b>12/28/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>1-1-56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>White Haven Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>White Haven, Wicomico Co. Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>JAN 2 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mary A. Stewart</b> <b>J. F. Stewart Funeral Home, Salisbury, Md.</b>			

# 2564 CERTIFICATE OF DEATH

1956

1. Name of deceased (Print or write)

2. Date of death (Month, day, year)

3. Place of death (City, town, or village)

4. Name of physician (Print or write)

5. Cause of death (Print or write)

6. Sex (Male or Female)

7. Age (Years, months, days)

8. Race (Print or write)

9. Marital status (Single, Married, Widowed, Divorced)

10. Occupation (Print or write)

11. Usual residence (Print or write)

12. Signature of physician (Print or write)

13. Signature of registrar (Print or write)

14. Signature of informant (Print or write)

15. Signature of witness (Print or write)

16. Signature of witness (Print or write)

17. Signature of witness (Print or write)

18. Signature of witness (Print or write)

19. Signature of witness (Print or write)

20. Signature of witness (Print or write)

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36. Signature of witness (Print or write)

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38. Signature of witness (Print or write)

39. Signature of witness (Print or write)

40. Signature of witness (Print or write)

BUREAU V. S.

JAN 2 1956

RECEIVED

EXHIBITION



## PR. Gilmore 12545 CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ocean City</u>		<u>23X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED: (Type or Print) <u>Gladys Walls West</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 8-1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widowed</u>		8. DATE OF BIRTH: <u>Aug-6-1896</u>	
9. AGE last birthday: <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House work at home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>John Wesley Walls</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S ADDRESS: <u>Mr. John Kling (Nephew) Felton R.D. #4 Del.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE				(A) <u>Cerebral Vascular Accident</u> 20 min.			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Cerebral Arteriosclerosis</u> Unknown			
				(C) <u>Myocardial Insufficiency</u> "			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchial Asthma</u>							
19A. DATE OF OPERATION: <u></u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/29/1955</u> , to <u>12/8/1955</u> , that I last saw the deceased alive on <u>11/29/1955</u> and that death occurred at <u>11/40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>David J. Gilmore</u>		M. D. <u>Salisbury, Md.</u>		DATE SIGNED <u>Dec 8/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec 11-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Lakeside Cemetery</u>		LOCATION (City, town, or county) (State) <u>Sever Del.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-9-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Kollman</u>		24. FUNERAL DIRECTOR <u>W. A. Torbert</u>		ADDRESS <u>Pover Del.</u>	

MARGIN RESERVED FOR PRINTING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12546

## CERTIFICATE OF DEATH

12530

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>BERLIN</u>		<u>23X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>BRYAN AVENUE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Wilde</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 3 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>NEWBORN</u>	8. DATE OF BIRTH		9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh Frederick Wilde</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Elizabeth Cropper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>18. MEDICAL CERTIFICATION</b>				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
18 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>12/2</u> , 19 <u>55</u> to <u>12/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/2</u> , 19 <u>55</u> , and that death occurred at <u>AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>12/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>		DATE THEREOF <u>12/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) <u>Salisbury Md</u>	
24. REC'D BY REGISTRAR <u>Mary W. Holloman</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	
DATE <u>12-3-55</u>							

CERTIFICATE OF DEATH

1955-1956

A. NAME OF DECEASED

MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

DEC 8 1955

RECEIVED

12554

## CERTIFICATE OF DEATH

Reg. Dist. No. 332.....

## 1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Hardela Springs - Rural LENGTH OF STAY (in this place) 17 years  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS San Domingo

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Hardela Springs - Rural X  
 STREET ADDRESS (If rural give location) San Domingo 1

## 3. NAME OF DECEASED:

(First) Cora (Middle) Lee (Last) Williams

4. DATE (Month) (Day) (Year)  
 OF DEATH: December 6 1955

## 5. SEX:

Female

## 6. COLOR OR RACE:

Colored

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

## 8. DATE OF BIRTH:

September 2, 1915

## 9. AGE last birthday

40 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housework

## 10B. KIND OF BUSINESS OR INDUSTRY:

Home

## 11. BIRTHPLACE (State or foreign country):

South Carolina

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

George Hill

## 14. MOTHER'S MAIDEN NAME:

Serella Robinson

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

Unknown

## 17. INFORMANT &amp; ADDRESS:

Julius S. Hill, 2416 N. Myrtlewood St., Philadelphia, Pa.

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

444-X

## IMMEDIATE CAUSE

(A) DUE TO

High Blood Pressure & Heartwork

## ANTECEDENT CAUSE (S)

(B) DUE TO

Responsibility above

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Heart suddenly

## INTERVAL BETWEEN ONSET AND DEATH

## 19A. DATE OF OPERATION:

0 -

## 19B. MAJOR FINDINGS OF OPERATION

-

## 20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1915, to March, 1955, that I last saw the deceased alive on June 10, 1955, and that death occurred at 7:45 AM, from the causes and on the date stated above.

SIGNATURE

Frederic J. J. J.

ADDRESS

M.D.

Hardela Springs, Md. Dec. 6, 1955

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

Dec. 10, 1955

## NAME OF CEMETERY OR CREMATORY

Mount Lawn Cemetery

## LOCATION (City, town, or county)

Philadelphia, Pennsylvania

(State)

## DATE REC'D BY LOCAL REGISTRAR

12-9-55

## REGISTRAR'S SIGNATURE

Mary W. Hollaway

## 24. FUNERAL DIRECTOR

J. J. Frampton and Son, Federalburg, Md.

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12532

12555

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Pantego</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pantego</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Ox2</u> (First) (Middle) (Last) <u>Willing</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 24</u> 19 <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-19-1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pantego, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Willing</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Willing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Harvey Willing, Pantego, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>420.0 Acute Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arteriosclerotic Heart Disease 5 years</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>31 Mar., 1955</u> , to <u>24 Dec., 1955</u> , that I last saw the deceased alive on <u>24 Dec., 1955</u> , and that death occurred at <u>10:59 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Delbert H. Sawdon, M.D.</u>				ADDRESS (Street, city, town, state) <u>Pantego, Md.</u>		DATE SIGNED <u>12/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Willing Private Cem.</u>		LOCATION (City, town, or county) (State) <u>Pantego, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 28 1955</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Cornelius D. Hershick</u>		ADDRESS <u>Bivaloe, Md.</u>	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12547 CERTIFICATE OF DEATH

12598

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DELMAR</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL Hospital</u>				STREET ADDRESS (If rural give location) <u>264 NO 2nd Street.</u> <u>V</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Wood Franklin M Daniel Wolfe</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 29 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>12-29-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES THOMAS Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Knitter McDaniel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
762.5 IMMEDIATE CAUSE (A) <u>Pulmonary atelectasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pneumonia</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 29, 1955</u> , to <u>Dec 29, 1955</u> , that I last saw the deceased alive on <u>Dec 29, 1955</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>[Address]</u>		DATE SIGNED <u>1-5-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>1-2-56</u>		<u>Parsons Cemetery</u>		<u>Salisbury, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-30-55</u>		<u>Mary W. Holloway</u>		<u>[Signature]</u>		<u>Holloway &amp; Co, Salisbury, Md.</u>	

2182203340

# CERTIFICATE OF DEATH

(To be filled out by the physician or other qualified person.)

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF CLERK

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF DEPUTY SHERIFF

25. SIGNATURE OF CONSTABLE

26. SIGNATURE OF JURY

27. SIGNATURE OF JUDGE

28. SIGNATURE OF CLERK

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF DEPUTY SHERIFF

31. SIGNATURE OF CONSTABLE

32. SIGNATURE OF JURY

33. SIGNATURE OF JUDGE

34. SIGNATURE OF CLERK

35. SIGNATURE OF SHERIFF

36. SIGNATURE OF DEPUTY SHERIFF

37. SIGNATURE OF CONSTABLE

38. SIGNATURE OF JURY

39. SIGNATURE OF JUDGE

40. SIGNATURE OF CLERK

41. SIGNATURE OF SHERIFF

42. SIGNATURE OF DEPUTY SHERIFF

43. SIGNATURE OF CONSTABLE

44. SIGNATURE OF JURY

45. SIGNATURE OF JUDGE

46. SIGNATURE OF CLERK

47. SIGNATURE OF SHERIFF

48. SIGNATURE OF DEPUTY SHERIFF

49. SIGNATURE OF CONSTABLE

50. SIGNATURE OF JURY

51. SIGNATURE OF JUDGE

52. SIGNATURE OF CLERK

53. SIGNATURE OF SHERIFF

54. SIGNATURE OF DEPUTY SHERIFF

55. SIGNATURE OF CONSTABLE

56. SIGNATURE OF JURY

57. SIGNATURE OF JUDGE

58. SIGNATURE OF CLERK

59. SIGNATURE OF SHERIFF

60. SIGNATURE OF DEPUTY SHERIFF

61. SIGNATURE OF CONSTABLE

62. SIGNATURE OF JURY

63. SIGNATURE OF JUDGE

64. SIGNATURE OF CLERK

65. SIGNATURE OF SHERIFF

66. SIGNATURE OF DEPUTY SHERIFF

67. SIGNATURE OF CONSTABLE

68. SIGNATURE OF JURY

69. SIGNATURE OF JUDGE

70. SIGNATURE OF CLERK

71. SIGNATURE OF SHERIFF

72. SIGNATURE OF DEPUTY SHERIFF

73. SIGNATURE OF CONSTABLE

74. SIGNATURE OF JURY

75. SIGNATURE OF JUDGE

76. SIGNATURE OF CLERK

77. SIGNATURE OF SHERIFF

78. SIGNATURE OF DEPUTY SHERIFF

79. SIGNATURE OF CONSTABLE

80. SIGNATURE OF JURY

81. SIGNATURE OF JUDGE

82. SIGNATURE OF CLERK

83. SIGNATURE OF SHERIFF

84. SIGNATURE OF DEPUTY SHERIFF

85. SIGNATURE OF CONSTABLE

86. SIGNATURE OF JURY

87. SIGNATURE OF JUDGE

88. SIGNATURE OF CLERK

89. SIGNATURE OF SHERIFF

90. SIGNATURE OF DEPUTY SHERIFF

91. SIGNATURE OF CONSTABLE

92. SIGNATURE OF JURY

93. SIGNATURE OF JUDGE

94. SIGNATURE OF CLERK

95. SIGNATURE OF SHERIFF

96. SIGNATURE OF DEPUTY SHERIFF

97. SIGNATURE OF CONSTABLE

98. SIGNATURE OF JURY

99. SIGNATURE OF JUDGE

100. SIGNATURE OF CLERK

101. SIGNATURE OF SHERIFF

102. SIGNATURE OF DEPUTY SHERIFF

103. SIGNATURE OF CONSTABLE

104. SIGNATURE OF JURY

105. SIGNATURE OF JUDGE

106. SIGNATURE OF CLERK

107. SIGNATURE OF SHERIFF

108. SIGNATURE OF DEPUTY SHERIFF

109. SIGNATURE OF CONSTABLE

110. SIGNATURE OF JURY

111. SIGNATURE OF JUDGE

112. SIGNATURE OF CLERK

113. SIGNATURE OF SHERIFF

114. SIGNATURE OF DEPUTY SHERIFF

115. SIGNATURE OF CONSTABLE

116. SIGNATURE OF JURY

117. SIGNATURE OF JUDGE

118. SIGNATURE OF CLERK

119. SIGNATURE OF SHERIFF

120. SIGNATURE OF DEPUTY SHERIFF

121. SIGNATURE OF CONSTABLE

122. SIGNATURE OF JURY

123. SIGNATURE OF JUDGE

124. SIGNATURE OF CLERK

125. SIGNATURE OF SHERIFF

126. SIGNATURE OF DEPUTY SHERIFF

127. SIGNATURE OF CONSTABLE

128. SIGNATURE OF JURY

129. SIGNATURE OF JUDGE

130. SIGNATURE OF CLERK

131. SIGNATURE OF SHERIFF

132. SIGNATURE OF DEPUTY SHERIFF

133. SIGNATURE OF CONSTABLE

134. SIGNATURE OF JURY

135. SIGNATURE OF JUDGE

136. SIGNATURE OF CLERK

137. SIGNATURE OF SHERIFF

138. SIGNATURE OF DEPUTY SHERIFF

139. SIGNATURE OF CONSTABLE

140. SIGNATURE OF JURY

141. SIGNATURE OF JUDGE

142. SIGNATURE OF CLERK

143. SIGNATURE OF SHERIFF

144. SIGNATURE OF DEPUTY SHERIFF

145. SIGNATURE OF CONSTABLE

146. SIGNATURE OF JURY

147. SIGNATURE OF JUDGE

148. SIGNATURE OF CLERK

149. SIGNATURE OF SHERIFF

150. SIGNATURE OF DEPUTY SHERIFF

151. SIGNATURE OF CONSTABLE

152. SIGNATURE OF JURY

153. SIGNATURE OF JUDGE

154. SIGNATURE OF CLERK

155. SIGNATURE OF SHERIFF

156. SIGNATURE OF DEPUTY SHERIFF

157. SIGNATURE OF CONSTABLE

158. SIGNATURE OF JURY

159. SIGNATURE OF JUDGE

160. SIGNATURE OF CLERK

161. SIGNATURE OF SHERIFF

162. SIGNATURE OF DEPUTY SHERIFF

163. SIGNATURE OF CONSTABLE

164. SIGNATURE OF JURY

165. SIGNATURE OF JUDGE

166. SIGNATURE OF CLERK

167. SIGNATURE OF SHERIFF

168. SIGNATURE OF DEPUTY SHERIFF

169. SIGNATURE OF CONSTABLE

170. SIGNATURE OF JURY

171. SIGNATURE OF JUDGE

172. SIGNATURE OF CLERK

173. SIGNATURE OF SHERIFF

174. SIGNATURE OF DEPUTY SHERIFF

175. SIGNATURE OF CONSTABLE

176. SIGNATURE OF JURY

177. SIGNATURE OF JUDGE

178. SIGNATURE OF CLERK

179. SIGNATURE OF SHERIFF

180. SIGNATURE OF DEPUTY SHERIFF

181. SIGNATURE OF CONSTABLE

182. SIGNATURE OF JURY

183. SIGNATURE OF JUDGE

184. SIGNATURE OF CLERK

185. SIGNATURE OF SHERIFF

186. SIGNATURE OF DEPUTY SHERIFF

187. SIGNATURE OF CONSTABLE

188. SIGNATURE OF JURY

189. SIGNATURE OF JUDGE

190. SIGNATURE OF CLERK

191. SIGNATURE OF SHERIFF

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193. SIGNATURE OF CONSTABLE

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